

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

10416

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10416

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Q.A. Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d. STREET ADDRESS <u>8332 Dock Rd. (Green Gables)</u>	
3. NAME OF DECEASED (Type or print) <u>Dr. Wayne Adams</u>		4. DATE OF DEATH Month <u>8</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1952</u>
9. AGE (In years lost birthday) <u>15</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Adams</u>		14. MOTHER'S MAIDEN NAME <u>Dolores Bloom</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Bowen</u> Address <u>Mrs. Dolores Bloom (mother)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> DUE TO (b) <u>929.9</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>-</u>		20d. INJURY OCCURRED <u>3</u> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Albert L. Anderson</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>ALBERT L. ANDERSON</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug - 30 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Pk.</u>		23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, Md. -</u>	
24. FUNERAL DIRECTOR <u>R. Singleton</u> ADDRESS <u>Singleton Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 30 1967</u>	



Handwritten text, mostly illegible due to blurriness and bleed-through. Some words like "Albert" and "Anderson" are faintly visible.

Handwritten text at the bottom of the page, including the name "ALBERT ANDERSON" written upside down.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10417

10417

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 8 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nevitt Steele ASQUITH		4. DATE OF DEATH Month August Day 2 Year 19 67	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1887	
9. AGE (In years last birthday) 79		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY Agricultural	
11. BIRTHPLACE (County & State, or foreign country) Edgewater Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Aisquith		14. MOTHER'S MAIDEN NAME Mary Virginia Ireland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Lucy B. Tucker - Annapolis, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive infarction, right cerebral hemisphere DUE TO (b) Cerebral arteriosclerosis DUE TO (c) years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from Aug. 2, 19 67 to Aug. 2, 19 67 that (I) (we) saw the deceased alive on Aug. 2, 19 67 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Richard I. Hochman M.D.		22b. DATE SIGNED 8/3/67	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d. ADDRESS 16 Murray Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 4, 1967	
23c. NAME OF CEMETERY OR CREMATORY Hope Chapel Cemetery		23d. LOCATION (City or Town) (County) (State) Edgewater A.A. Md.	
24. FUNERAL DIRECTOR Hopping Funeral Home - Annapolis, Md.		25a. REC'D BY REGISTRAR DATE AUG 7 1967	
25b. REGISTRAR'S SIGNATURE Charles J. J...			

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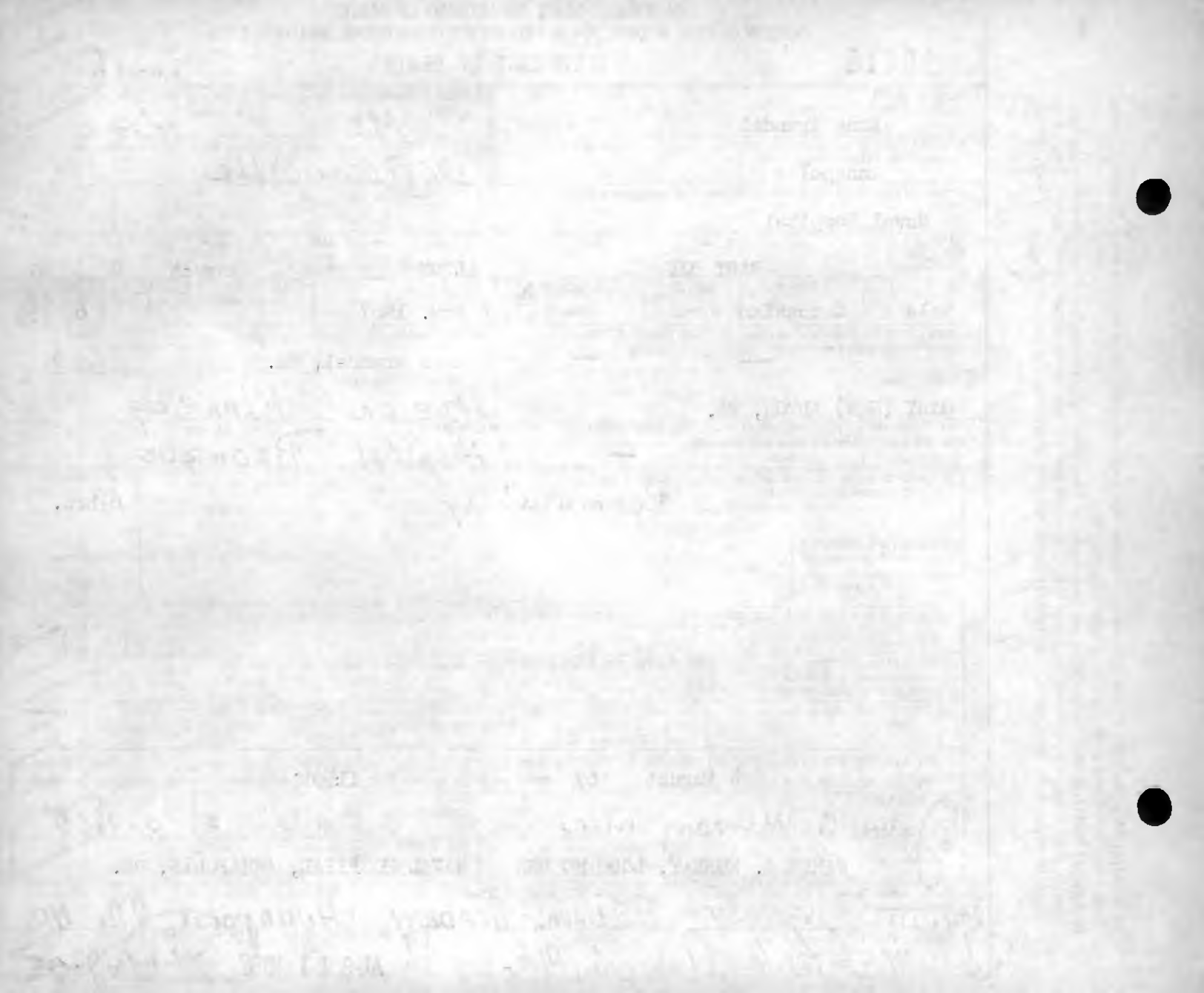
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10418

CERTIFICATE OF DEATH

10418

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAVIDSONVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BABY BOY First Middle Last ALTON				4. DATE OF DEATH Month August Day 8 Year 19 67			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 Aug. 1967		9. AGE (In years lost birthday) yrs. 6 Months 8 Days 58		10. IF UNDER 1 YEAR Months 6 Days 8 Hours 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GARY (NMN) ALTON, SR.				14. MOTHER'S MAIDEN NAME Adrian Klakring			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8 August 1967 , 19 67 , that (I) (we) last saw the deceased alive on 8 August 1967 , and that death occurred at 11:50 M. from causes and on the date stated above.							
22a. SIGNATURE James A. Murray M.D.				22b. DATE SIGNED 8-9-67		22c. PHYSICIAN'S NAME (Type) JAMES A. MURRAY, LCDR MC USN	
22d. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8-10-67		23c. NAME OF CEMETERY OR CREMATORY U.S. NAVAL ACADEMY		23d. LOCATION (City or Town) (County) (State) Annapolis A.A. MD.	
24. FUNERAL DIRECTOR John M. & Ly Parfais Annapolis, Md.				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
25c. DATE AUG 11 1967				25d. DATE AUG 11 1967			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10419

10419

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AACO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARNOLD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DON-ANNE-ARNOLD-Gen.</u>		d. STREET ADDRESS <u>Dividing Creek Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>F</u> Last <u>BACHMANN</u>		4. DATE OF DEATH Month <u>8</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/15/07</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Econ. Typist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>HENRY A. Bachmann</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Hertenberger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic disease</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhart</u>		22. DATE SIGNED <u>8/21/67</u>	
EXAMINER'S NAME (Type) <u>E. Linhart</u>		M.D. <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-25-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Western Com</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto, Md.</u>	
24. FUNERAL DIRECTOR <u>Severna Park for the Chapel</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 24 1967</u>	
ADDRESS <u>Severna Park, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1881

1882

March

1883

April

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1885

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1892

10420

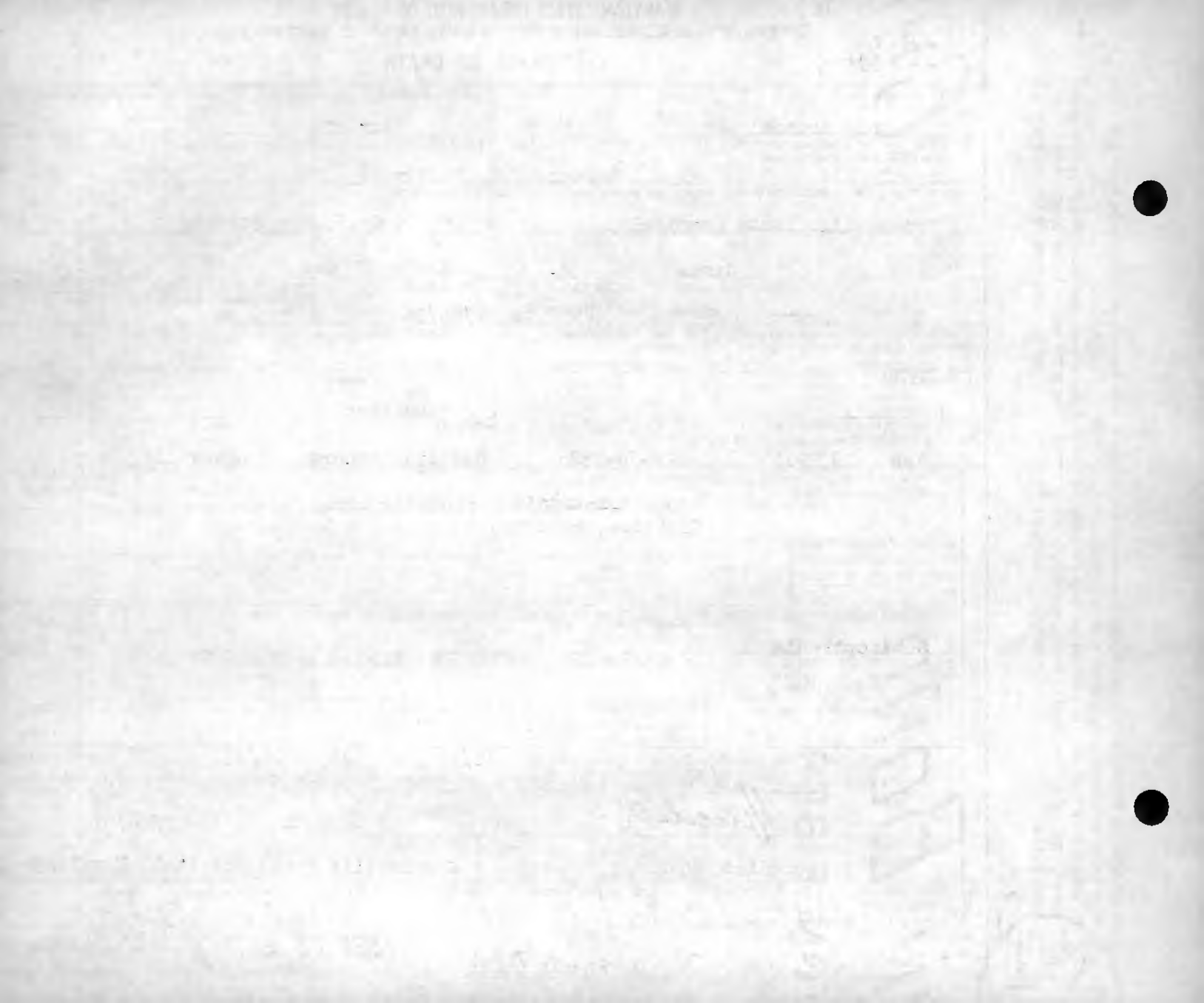
11832

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James A. Bell</u>		4. DATE OF DEATH Month Day Year <u>8 27 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. B. DATE OF BIRTH <u>1/24/36</u>
9. AGE (In years last birthday) yrs. <u>31</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Bell</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 1952-1958</u>		16. SOCIAL SECURITY NO. <u>220-30-5325</u>	
17. INFORMANT <u>Hospital Records, Crownsville, Maryland</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia; Diabetic coma</u> DUE TO (b) <u>Diabetes, mellitus</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/4</u> , 19 <u>63</u> , to <u>8/27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/27</u> , 19 <u>67</u> , and that death occurred at <u>2:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>L. Benedict, M.D.</u>		22b. DATE SIGNED <u>8/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>9/12/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto. Md.</u>
24. FUNERAL DIRECTOR <u>William Reese, Jr. - Annapolis, Md.</u>		25a. RECEIVED BY REGISTRAR <u>SEP 15 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James Judge</u>		25c. REGISTRAR'S NAME <u>James Judge</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>	
c. LENGTH OF STAY IN TB <u>11 yrs.</u>		d. STREET ADDRESS <u>Rte. 1, Box 60, Pinehurst</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rte. 1, Box 60, Pinehurst</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James V. Benson</u>		4. DATE OF DEATH <u>August 25, 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 Sept. 1909</u>
9. AGE (In years last birthday) <u>57 yrs.</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self - Employed</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>AA County</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James R. Benson</u>		14. MOTHER'S MAIDEN NAME <u>Anna R. Stallings</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-30-5694</u>	
17. INFORMANT <u>Mrs. Helen K. Benson, same as 2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RETICULUM CELL SARCOMA</u> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from <u>AUG 15, 1966</u> to <u>AUG 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>AUG. 25, 1967</u> , and that death occurred at <u>8:54 AM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>John H. Tuohy</u>		22b. DATE SIGNED <u>8/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN H. TUOHY, MD</u>		22d. ADDRESS <u>ST. AGNES HOSP., BALTO., MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>28 Aug. 67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		23d. LOCATION (City, town or county) <u>Glen Burnie, Md.</u>	
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>g Charles Judge</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10421

10122

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>ANNAPOLIS</u> b. STATE <u>MD</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANNAPOLIS</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>ANNAPOLIS, MD</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>H. H. GENERAL Hospt.</u>		d. STREET ADDRESS <u>2 PAFEEH ROAD</u>	
3 NAME OF DECEASED (Type or print) <u>Charles</u> First <u>A</u> Middle <u>Berry</u> Last		4 DATE OF DEATH <u>8/26/67</u> Month <u>8</u> Day <u>26</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 CO. OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10/4/19</u> 9 AGE (In years, lost, birth day) <u>54</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>YACHT YARD</u>	
11 BIRTHPLACE (State or foreign country) <u>ANNAPOLIS, MD.</u>		12 C. I. ZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13 FATHER'S NAME <u>GEORGE BERRY</u>		14 MOTHER'S MAIDEN NAME <u>GRACE CARSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOC. A. SECURITY NO. <u>—</u>	
17 INFORMANT <u>Vivian S. BERRY #2</u> Address <u>—</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>① acute dilatation of the heart</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>—</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour am <u>—</u> pm <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Albert P. Anderson</u> M.D.		22 DATE SIGNED <u>ANNAPOLIS, MD.</u>	
EXAMINER'S NAME (Type) <u>ALBERT ANDERSON</u>		Address (Street, city, town, or county) <u>ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, or other disposition <u>BURIAL</u>	23b. DATE THEREOF <u>8-29-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>	23d. LOCATION (City or town) (County) (State) <u>ANNAPOLIS MD.</u>
24 FUNERAL DIRECTOR <u>John M. Lybo</u> Address <u>ANNAPOLIS, MD.</u>		25a. REC'D BY REGISTRAR <u>AUG 29 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 5 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10423

CERTIFICATE OF DEATH

10422

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Maud B. BERRY		4. DATE OF DEATH Month August Day 8 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1892
9 AGE (in years last birthday) 74 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
10b KIND OF BUSINESS OR INDUSTRY HOME		11 BIRTHPLACE (County & State, or foreign country) Canada	
12 CITIZEN OF WHAT COUNTRY? U.S.		13 FATHER'S NAME Arthur Bountree	
14 MOTHER'S MAIDEN NAME Bose Sutton		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO —		17 INFORMANT PETER BERRY #2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO 5705 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Intestinal Obstruction DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 HRS 48 HRS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Depressive Cardiovascular Disease		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ALL DEATH WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (has been) attended the deceased from June 1st , 19 67 to Aug. 8 , 19 67 , that (I) (was) saw the deceased alive on Aug. 8 , 19 67 , and that death occurred at 1:20 AM , from causes and on the date stated above.			
22a SIGNATURE Edward S. Beck		22b DATE SIGNED 9/9/67	
22c PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.		22d ADDRESS 73 Franklin St., Annapolis, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 8-11-1967	23c NAME OF CEMETERY OR CREMATORY Oakwood Cemetery	23d LOCATION (City or Town) (County) (State) Chicago Ill.
24 FUNERAL DIRECTOR John M. Taylor & Sons Annapolis, Md.		25a REC'D BY REGISTRAR AUG 11 1967	25b REGISTRAR'S SIGNATURE John M. Taylor



CERTIFICATE OF DEATH

10423

10423

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>Rural - Riviera Beach</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d. STREET ADDRESS <u>241 Arundel Road #21122</u>	
3. NAME OF DECEASED (Type or print) <u>Alvina (Balbina) Blaszczyk</u>		4. DATE OF DEATH <u>August 6th 19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1, 1883</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>19</u> Hours <u>67</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>? Lube</u>		14. MOTHER'S MAIDEN NAME <u>Nancy ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Clara Hilditch - 241 Arundel Road #21122</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma Breast with Metastases</u> 110X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 1965</u> to <u>July 1967</u> , that (I) (we) last saw the deceased alive on <u>8/4 1967</u> , and that death occurred at <u>12:35</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>J. Brady Smith</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>		22d. ADDRESS <u>PASADENA, MD</u>	
23a. BURIAL, CREMATON, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug. 9, 1967</u>	23c. NAME OF CEMETERY OR <u>St. Stanislaus</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>George A. Weber - 705 South Ann Street #21231</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 9 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10425

10424

1. PLACE OF DEATH a. COUNTY <u>A.A. Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>A.A. Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. LENGTH OF STAY IN 1b <u>2 year</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>649 Kensington Ave</u>				d. STREET ADDRESS <u>649 Kensington Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HELGA E. BOYKIN</u>				4. DATE OF DEATH Month <u>8</u> Day <u>31</u> Year <u>1967</u>			
5. SEX <u>FEM</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-21-23</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (County & State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Alto Mueshold</u>			
14. MOTHER'S MAIDEN NAME <u>Louisa Henrichs</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>-</u>				17. INFORMANT <u>Curtis R. Boykin</u> Address <u>Severna Park</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca of ovaries i gen.</u> DUE TO (b) <u>metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar</u> , 19 <u>66</u> , to <u>Aug 31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/30</u> 19 <u>67</u> , and that death occurred at <u>9:30 PM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>S. Bonssuck</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>9/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. Bonssuck</u>				22d. ADDRESS <u>Severna Park</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>9-5-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lawrence CEM.</u>		23d. LOCATION (City or town) (County) (State) <u>Severna Park A.A.</u>	
24. FUNERAL DIRECTOR <u>Robert S. Baranov</u>				25a. REC'D BY REGISTRAR <u>SEP 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10425

CERTIFICATE OF DEATH

10425

1. PLACE OF DEATH ANNE ARUNDEL a. COUNTY NORTH ARUNDEL CONV. HOME b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN lb 15 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL CONV. HOME				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 921 Stoll St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Wilbur Bracken First Middle Last				4. DATE OF DEATH Month 8 Day 12 Year 1967			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-15-1907 60 yrs	
9. AGE (In years last birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tire Co. Armor SALESMAN		11. BIRTHPLACE (County & State, or foreign country) JOHNSTOWN, PENN		12. CITIZEN OF WHAT COUNTRY? Yes	
13. FATHER'S NAME Silas Bracken				14. MOTHER'S MAIDEN NAME Mary Leckey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carumona, Medial Lobe DUE TO Carumona, Bronchus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH 5 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-29 , 19 67 , to 8-12 , 19 67 , that (I) (we) last saw the deceased alive on 8-11 , 19 67 , and that death occurred at 1:40 PM, from causes and on the date stated above.							
22a. SIGNATURE Benjamin Sordani				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/12/67	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, or other disposition Buried		23b. DATE THEREOF 8/14/67		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem		23d. LOCATION (City or Town) (County) (State) AA Co Md	
24. FUNERAL DIRECTOR McGully F H 237 Patapsco Ave 21225				25a. REC'D BY REGISTRAR AUG 14 1967		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10427

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 2½ Years		d. STREET ADDRESS 722 Cumberland Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House of Correction		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Nathan Solomon Brewer, Jr.		4. DATE OF DEATH Month Day Year August 27 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-33
9. AGE (In years last birthday) yrs. 34		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevedore		10b. KIND OF BUSINESS OR INDUSTRY Shipyard	
11. BIRTHPLACE (County & State or foreign country) Woodbury, New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nathan Sr.		14. MOTHER'S MAIDEN NAME Florence (nee Baniard)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1950-52		16. SOCIAL SECURITY NO 2-3-30-0005	
17. INFORMANT Medical Records - House of Correction		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epicypsis-neuroepithelioma DUE TO peri-orbital area Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) long metastases to cervical spine & pelvis DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 1966 , to Aug. 27, 1967 , that (I) (we) last saw the deceased alive on Aug. 27 1967 , and that death occurred at 8:50 PM , from causes and on the date stated above.			
22a. SIGNATURE Rolando V. Goco		22b. DATE SIGNED 8-27-67	
22c. PHYSICIAN'S NAME (Type) Rolando V. Goco		22d. ADDRESS 8th & Gorman, Laurel, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 8/5/67	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City or Town) (County) (State) Baltimore Md
24. FUNERAL DIRECTOR Wm P Carroll 1712 W. North Ave		25a. REC'D BY REGISTRAR DATE AUG 30 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
 20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
10428											
10427											
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Glen Burnie, Md</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					
c. LENGTH OF STAY IN 1b <u>28 months</u>						d. STREET ADDRESS <u>2426 Woodbrook Rd.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cooper Convalescent Home</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>SAMUEL FERCY</u>						4. DATE OF DEATH <u>Bright</u> 8 24 1967					
5. SEX <u>Male</u>						6. COLOR OR RACE <u>Negro</u>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>7/25/1890</u>					
9. AGE (In years last birthday) <u>77</u> yrs.						10. IF UNDER 1 YEAR Months Days					
11. IF UNDER 24 HRS. Hours Min.						12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Drug Store</u>					
11. BIRTHPLACE (County & State, or foreign country)						12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>					
13. FATHER'S NAME <u>UNKNOWN SAMUEL P. BRIGHT</u>						14. MOTHER'S MAIDEN NAME <u>UNKNOWN FRANCES SMITH</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>						16. SOCIAL SECURITY NO. <u>214-83-4826</u>					
17. INFORMANT <u>MARIA F. Cooper</u>						18. ADDRESS <u>406 Morris Hill Ave Glen Burnie, Md</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Hemorrhage</u>											
(c) <u>Hypertensive Cardiovascular Disease</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death 2 weeks</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>5-13-1966</u> to <u>8-24-1967</u> , that (I) (we) last saw the deceased alive on <u>8-23-1967</u> , and that death occurred at <u>6:00</u> M., from the causes and on the date stated above.											
22a. SIGNATURE <u>Richard H. Hunt</u> M.D.											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Hunt</u>											
22d. ADDRESS <u>100 Cherry Lane, Glen Burnie, Md</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>											
23b. DATE THEREOF <u>8-28-67</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>											
23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. New</u> ADDRESS <u>802 Madison Ave.</u>											
25a. NOTARY REGISTRAR <u>AUG 29 1967</u> DATE											
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

MEDICAL CERTIFICATION



10429

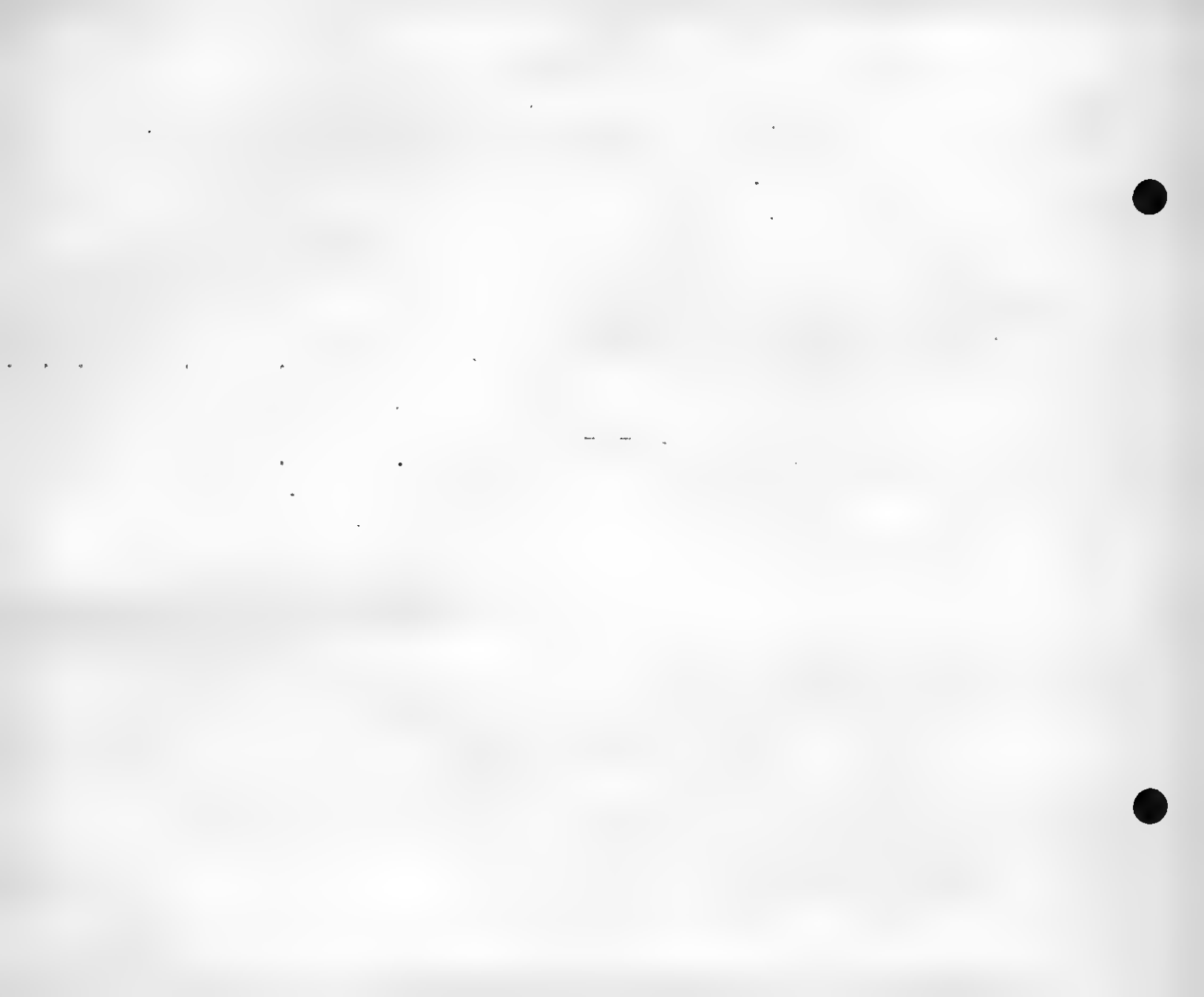
CERTIFICATE OF DEATH

10428

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park, Md. c. LENGTH OF STAY IN 1b 2 years			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Pennsylvania b. COUNTY Allegheny c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Allison Park		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 113 Holly Avenue			d. STREET ADDRESS 4365 Winchester Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Donald George Brown			4. DATE OF DEATH Month Day Year 8 21 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/20	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 19 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teaching		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Allegheny County, Penna.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Robert Emmet Brown		
14. MOTHER'S MAIDEN NAME Ellen Marian Dougherty			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII 2/11/42-3/30/46 Korea 1/22/50-5/14/52		
16. SOCIAL SECURITY NO. 171-48-5078			17. INFORMANT Address Mrs. Donald G. Brown Severna Park		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Squamous cell carcinoma, Left lung DUE TO with Metastasis. Inoperable. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					INTERVA. BETWEEN ONSET AND DEATH 6 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Feb. , 1967, to Aug. , 1967, that (I) (we) lost the deceased alive on July , 1967, and that death occurred at 2A M, from causes and on the date stated above					
22a. SIGNATURE Francis I. Codd M.D.		22b. DATE SIGNED 8-21-67		22c. PHYSICIAN'S NAME (Type) Francis I. Codd M.D.	
22d. ADDRESS Severna Park, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-24-67	23c. NAME OF CEMETERY OR CREMATORY Broaddock Catholic Cemetery Broaddock Hills Pa.	23d. LOCATION (City or Town)	(County)	(State)
24. FUNERAL DIRECTOR Living Byers 8728 Liberty Road		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10480

10429

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY in 1b <u>4 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. STREET ADDRESS <u>1928 McCulloh Street</u>	
3. NAME OF DECEASED (Type or print) <u>Thomas Brown</u>		4. DATE OF DEATH Month <u>8</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1911</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>contractors work</u>		9. AGE (In years last birthday) <u>56</u> yrs.	10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Hospital Records, Crownsville, Maryland</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Vascular Heart Disease</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus, Cerebral Spinal Syphilis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from <u>5/14</u> , 1953, to <u>8/7</u> , 1967, that the (we) lost saw the deceased alive on <u>8/7</u> , 1967, and that death occurred at <u></u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>L. Benedict</u>		22b. DATE SIGNED <u>8/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville, State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Type) <u>Burial</u>	23b. DATE THEREOF <u>8/12/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>
24. FUNERAL DIRECTOR <u>Adolphus Halstead</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 11 1967</u>	
ADDRESS <u>1206 W North Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

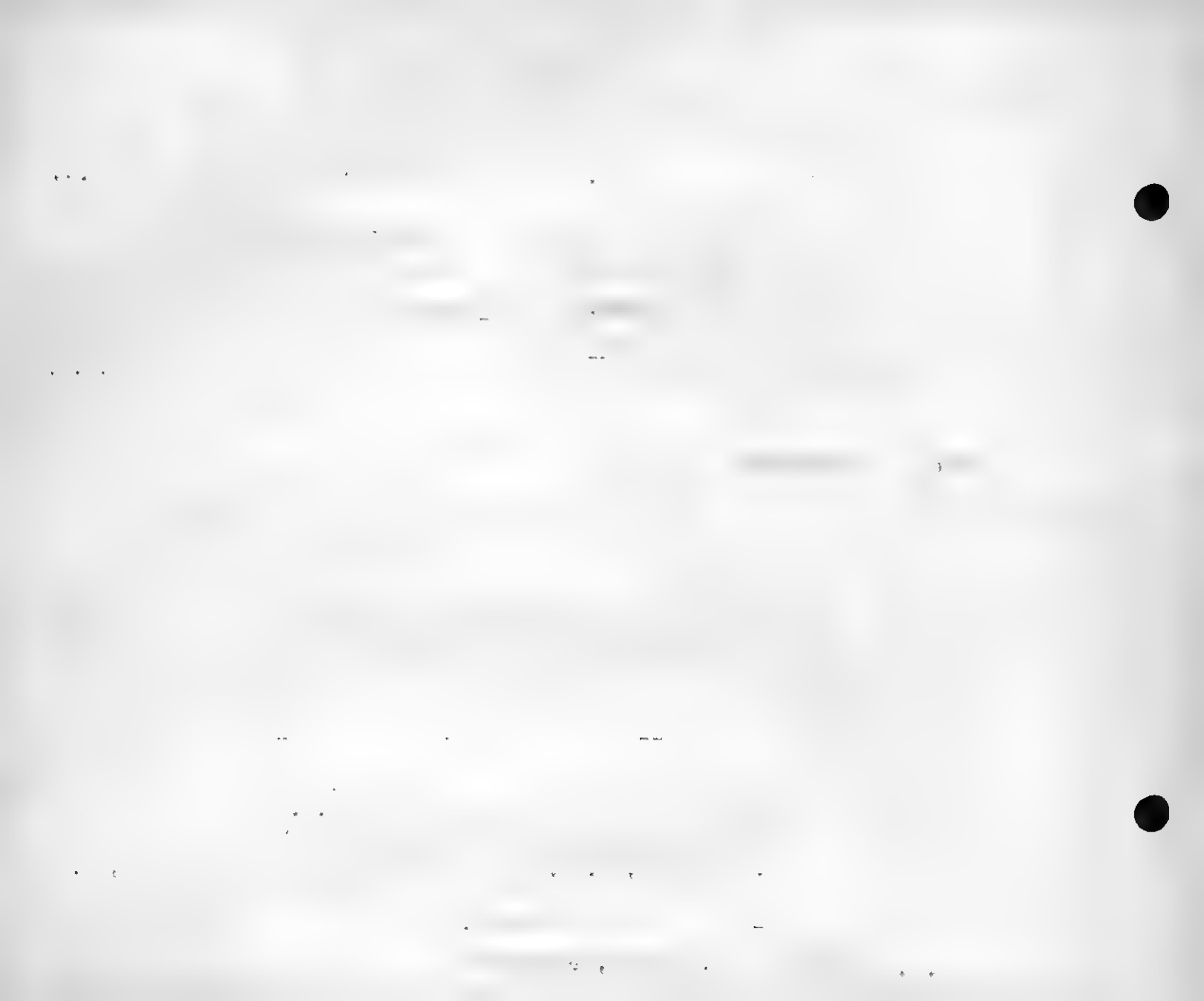
10431

CERTIFICATE OF DEATH

10430

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN TB 3mos. 15 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Barren Bay: Sorverna Park P.O.	
3. NAME OF DECEASED (Type or print) 3-#35226 William NMN Brown		4. DATE OF DEATH Month 8 Day 2 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED X	8. DATE OF BIRTH 7-7-1906
9. AGE (in years last birthday) 61 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Henry Brown		14. MOTHER'S MAIDEN NAME Lavine Jackson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No *****		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Hospital Records		Address Crownsville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Chemodectoma with extensive metastases DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Benign Prostatic Hypertrophy with G-U Tract obstruction.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. ----- 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/17 , 19 67 , to 8/2 , 19 67 , that (I) (we) lost saw the deceased alive on 8/2 , 19 67 , and that death occurred at 12:15 , from causes and on the date stated above			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 8/2/67	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-5-1967	23c. NAME OF CEMETERY OR CREMATORY Carpenters Hill	23d. LOCATION (City or Town) (County) (State) Anne Arundel Md
24. FUNERAL DIRECTOR C.E. Hicks, 111 Annapolis, Maryland		25a. REC'D BY REGISTRAR AUG 8 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	



10432

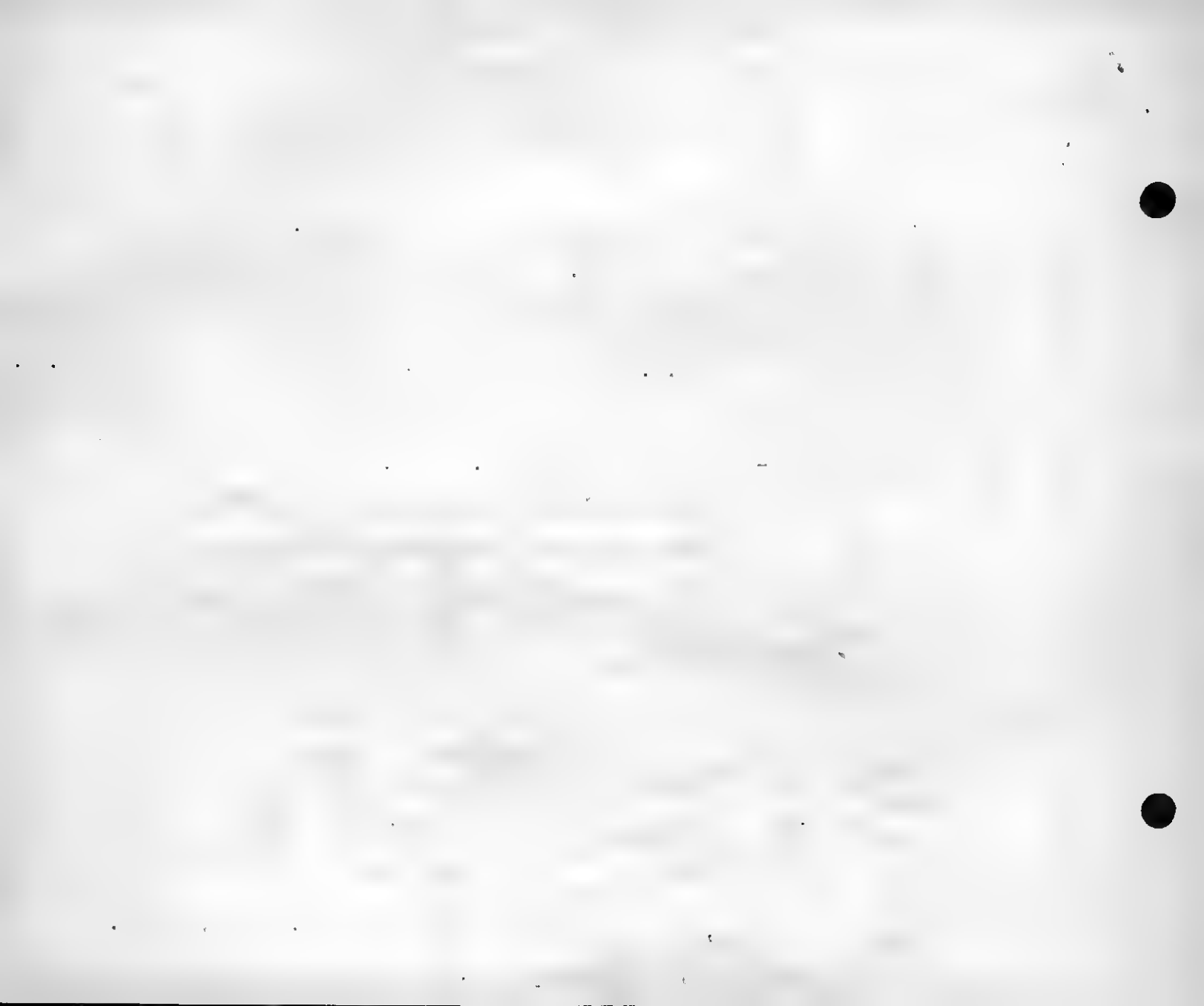
CERTIFICATE OF DEATH

10431

1 PLACE OF DEATH a COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Anne Arundel</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c LENGTH OF STAY IN TB <u>////</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d STREET ADDRESS <u>1812 Tower Rd.</u>	
3 NAME OF DECEASED (Type or print) First <u>Jack</u> Middle <u>C.</u> Last <u>Buckley</u>		4 DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-24</u>
9. AGE (In years last birthday) <u>42</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier (ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Detroit, Mich.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13 FATHER'S NAME <u>Roy Buckley</u>		14 MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>yes 1941-66</u>		16 SOCIAL SECURITY NO. <u>380/12/8714</u>	
17. INFORMANT <u>(wife)</u> Address <u>Same as</u>		<u>Mrs. Ann R. Buckley</u> <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac standstill, sudden</u> DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>Arteriosclerotic heart dis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>48/24</u>	20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>8/24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/24</u> , 19 <u> </u> , and that death occurred at <u>7:30</u> M from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>August 25, 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>VA SH</u>		22d. ADDRESS <u>206 S. S. Union St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>August 28, 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City or Town) (County) (State) <u>Ft. Meyer, Va.</u>
24. FUNERAL DIRECTOR <u>Eugene B. Flanning</u> <u>Singleton Funeral Home, Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

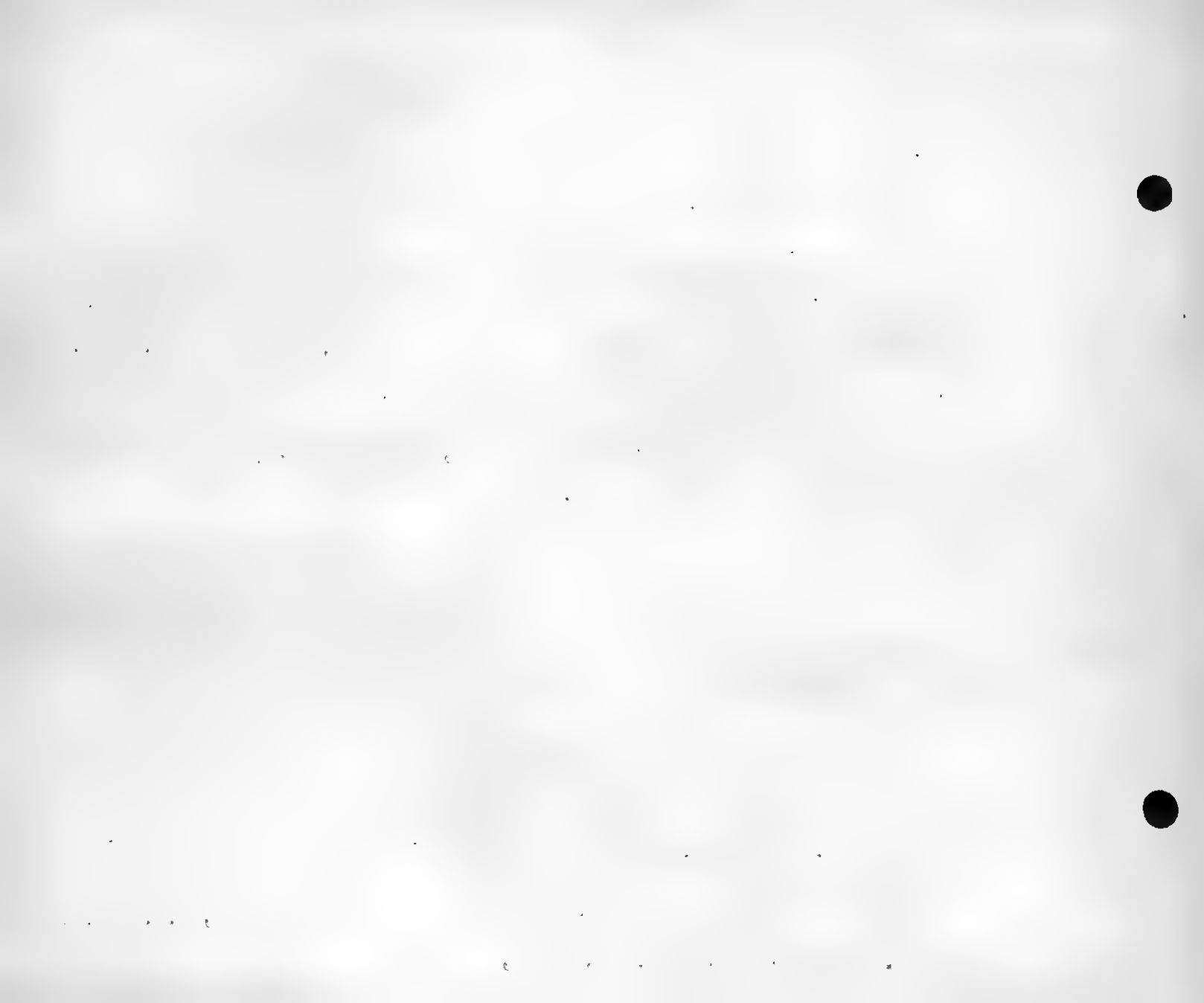
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
10433 CERTIFICATE OF DEATH 10432															
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie						c. LENGTH OF STAY IN 1b 36 hrs.			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brooklyn Park						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital						d. STREET ADDRESS 311 Fifth Avenue						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Grace - Carey				4. DATE OF DEATH Month Day Year August 27 1967											
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 25, 1967		9. AGE (In years last birthday) yrs. Months Days Hours Min. 36 00 00 00 00		10. UNDER 1 YEAR		11. UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles Edward Carey						14. MOTHER'S MAIDEN NAME Irene Whilelmina Gross									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. None		17. INFORMANT Mother, Mrs Irene Carey Balto, Md		Address 311 5th Ave 21225							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO												INTERVAL BETWEEN ONSET AND DEATH 36 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Aug. 25, 1967, to Aug. 27, 1967, that (I) (we) last saw the deceased alive on Aug. 27, 1967, and that death occurred at 11 AM, from the causes and on the date stated above.															
22a. SIGNATURE Allen Y. Wolins						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/27/67							
22c. PHYSICIAN'S NAME (Type) Dr. Allen Wolins						22d. ADDRESS 8319 Burningwood Rd. Fikesville, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Aug 28, 1967		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Park				23d. LOCATION (City, town or county) (State) Ritchie Hwy, A.A. Co G.R. Md					
24. FUNERAL DIRECTOR George J. Gonce						ADDRESS 4001 Ritchie Hwy, Balto, Md		25a. REC'D BY REGISTRAR SEP 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					



FOR STATE
HEALTH DEPT.

10434

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10433

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CORRECTION AUTHORIZED BY DR. LINDHEART - 8/13/67

1 PLACE OF DEATH a. COUNTY <u>AACCO.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS.</u> c. LENGTH OF STAY IN lb		2 USUAL RESIDENCE (Where deceased lived if institutional; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON DC.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>412</u>	
3 NAME OF DECEASED (Type or print) <u>ERIC D. CARROLL, SR</u> First <u>CARROLL, SR</u> Middle <u>Lost</u>		4 DATE OF DEATH Month <u>8</u> Day <u>12</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>N</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/22/23</u>
9 AGE (In years last birthday) <u>44</u> yrs		10 IF UNDER 1 YEAR Months <u>12</u> Days <u>19</u> Hours <u>67</u> Min.	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAB DRIVER</u>		12 KIND OF BUSINESS OR INDUSTRY <u>PRIVATE</u>	
13 BIRTHPLACE (State or foreign country) <u>Florida</u>		14 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15 FATHER'S NAME <u>CLEARANCE DEAN</u>		16 MOTHER'S M A DEN NAME <u>JULIA TURNQUEST</u>	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WUW</u>		18 SOCIAL SECURITY NO <u>ALMEDA CARROLL-649-KENNEDY</u>	
19 INFORMANT <u>NE</u> Address <u>649-KENNEDY</u>		20 INTERVAL BETWEEN ONSET AND DEATH <u>Stroke</u>	
21 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>251X</u> DUE TO <u>Stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Stroke</u> (c)			
PART 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) <u>Stroke</u>			
22a EXTERNAL CAUSE WAS PR MARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>Stroke</u>		22b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <u>Stroke</u>	
23a TIME OF INJURY Month, Day, Year Hour a.m. <u>pm</u> <u>8/9</u> 19 <u>67</u>	23d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	23e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Charles St.</u>	23f (City or town) <u>St. Anne</u> (County) <u>MD</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. H. H. H. H. H.</u>		22. DATE SIGNED <u>8/12/67</u>	
EXAMINER'S NAME (Type) <u>E. L. H. H. H. H. H.</u>		23b NAME OF CEMETERY OR CREMATORY <u>Harmony Memorial Park</u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23c DATE THEREOF <u>Aug-15-1967</u>	
23d LOCATION (City or town) <u>Prince Georges County, Md.</u>		23e REC'D BY REG STRAR <u>Charles Judge</u>	
23f REGISTRAR'S SIGNATURE <u>Charles Judge</u>		23g DATE <u>AUG 22 1967</u>	
24. FUNERAL DIRECTOR <u>John T. Rhines Company</u> 3015 12th Street, N. E., Washington, D. C.			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10434

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1005. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a COUNTY <u>M.A. CO.</u> MARYLAND		USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE <u>WASH. DC.</u> b COUNTY <u>47-3</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>MINNAPOLIS</u>		c LENGTH OF STAY IN 1b	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d NAME OF HOSPITAL OR INSTITUTION (If not in hosp to, give street address) <u>D.O.H. - Anne Arundel General</u>		d STREET ADDRESS <u>649 Kennedy St. NE</u>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <u>ERICK</u> Middle <u>Carroll</u> Last <u>Je</u>		4 DATE OF DEATH Month <u>8</u> Day <u>10</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>N</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>OCT. 24, 1957</u>
9 AGE (In years lost birthday) <u>9</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10b KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11 BIRTHPLACE (State or foreign country) <u>WASHINGTON, DC</u>
12 CITIZEN OF WHAT COUNTRY <u>USC.</u>		13 FATHER'S NAME <u>ERICK CARROLL</u>	
14 MOTHER'S MAIDEN NAME <u>ALMEDA SCOTT</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16 SOCIAL SECURITY NO. <u>NONE</u>		17 INFORMANT <u>ALMEDA SCOTT-649 KENNEDY ST NE</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Boating accident</u>	
20c TIME OF INJURY Month, Day, Year <u>8/9 1967</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Boating</u>	20f (City or town) (County) (State) <u>APLW MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Howard</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Howard</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>8/10/67</u>	
23a BURIAL, CREMATION, REBURYAL (Specify)	23b DATE THEREOF <u>Aug. 15, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Harmony Memorial Park</u>	23d LOCATION (City or town) (County) (State) <u>Prince Georges County, Md.</u>
24 FUNERAL DIRECTOR <u>John T. Rhines Company</u>		25a REC'D BY REGISTRAR <u>AUG 22 1967</u>	
3015 12th Street, N. E., Washington, D. C.		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



23



FOR STATE HEALTH DEPT

10436

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11502

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death has been ascertained. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

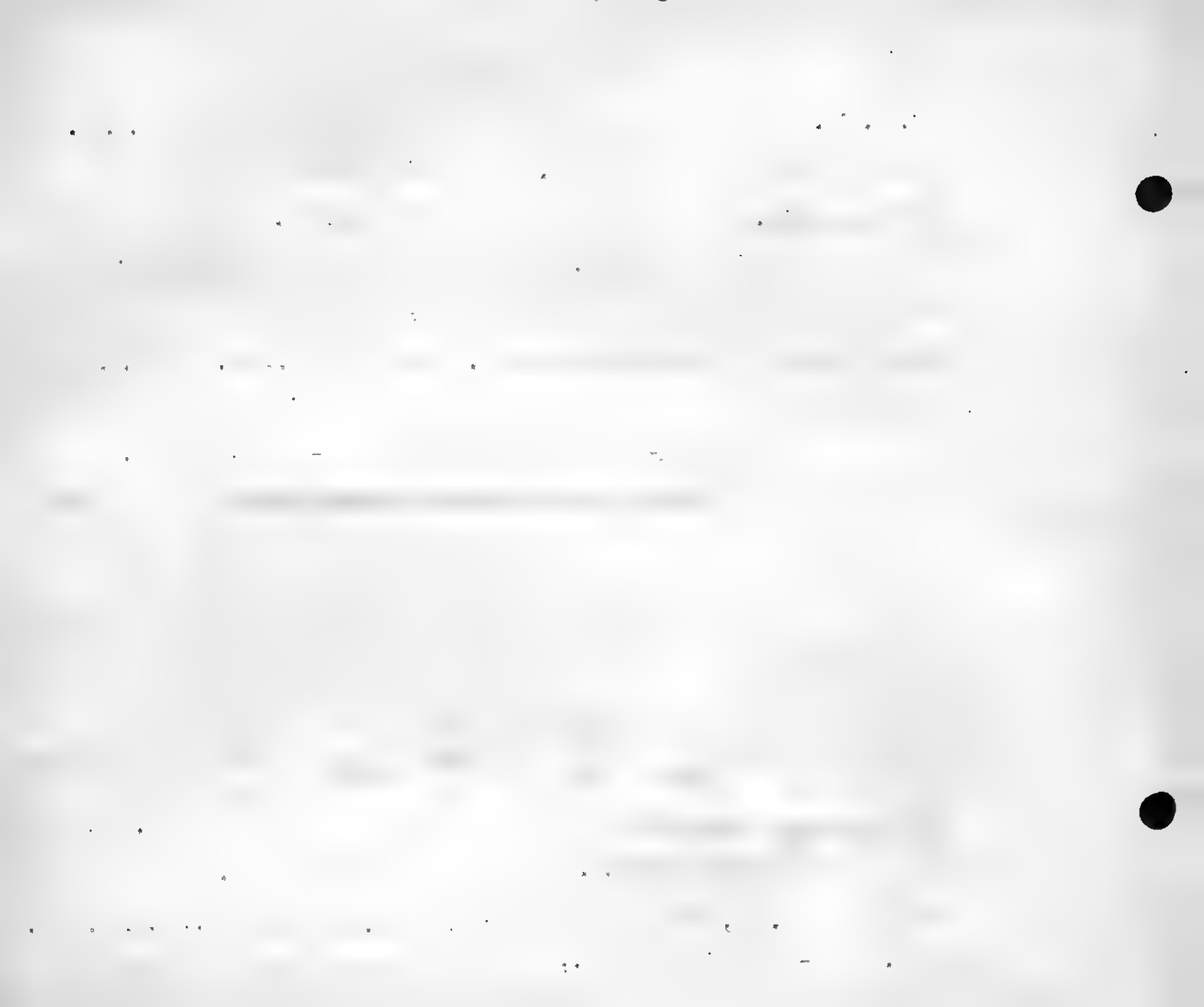
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>(Found in Chesapeake Bay, off QUEEN ANNES Metapeake Landing, ANNAPOLIS)</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>D.O.A. ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Baltimore</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>2830 Harlem Avenue</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>SUZANNE</u> Last <u>CARTER</u>		4. DATE OF DEATH <u>August 29, 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>SEPARATED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>9-8-38</u>
9. AGE (In years last birthday) <u>28</u> yrs		10. IF UNDER 1 YEAR Months <u>28</u> Days <u>18</u> Hours <u>18</u> Min <u>18</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse State Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Pierce</u>	
14. MOTHER'S MAIDEN NAME <u>Ernestine Summers</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>2/6-34-5/78</u>	
16. SOCIAL SECURITY NO. <u>216-34-5789</u>		17. INFORMANT <u>Ernestine Pierce 2830 Harlem</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: <u>981X</u> IMMEDIATE CAUSE (a) <u>Gunshot wounds of head</u> DUE TO (b) <u>Shot in head; weight tied to ankle; body put in Bay</u> DUE TO (c) <u>Shot in head; weight tied to ankle; body put in Bay</u> Conditions, if any, which give rise to immediate cause (a), stating the underlying cause lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS A POSTMORTEM PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Shot in head; weight tied to ankle; body put in Bay</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>?</u> p.m. <u>?</u> 19 <u>67</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>?</u>	20f. (City or town) (County) (State) <u>?</u> <u>?</u> <u>?</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles S. Springate</u> M.D.		22. DATE SIGNED <u>September 3, 1967</u>	
EXAMINER'S NAME (Type) <u>Charles S. Springate, M.D.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-6-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	23d. LOCATION (City or town) (County) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR <u>Washington S. Phillips 1727 N. Main St.</u>		25a. REC'D BY REGISTRAR <u>SEP 11 1967</u>	25b. REGISTRAR'S SIGNATURE <u>John J. Jones</u>

MR A15 (4) ~
DOM 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
10437					10435									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY A. A. Co.					a. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach					b. COUNTY A. A. Co.									
c. LENGTH OF STAY IN ID 26 yrs.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8430 Church Rd.					d. STREET ADDRESS 8430 Church Rd.									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX			6. COLOR OR RACE					
First STUART			Middle G.			Last CATHCART			Month August					
Day 21			Year 1967			Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>			White <input checked="" type="checkbox"/> Black <input type="checkbox"/>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH May 29, 1904			9. AGE (In years last birthday) 63			10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brewery Worker			10b. KIND OF BUSINESS OR INDUSTRY National Brewing Co.			11. BIRTHPLACE (County & State, or foreign country) Baltimore Co., Md.			12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME William Cathcart					14. MOTHER'S MAIDEN NAME Otilia Ditzell									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 216-09-9624					17. INFORMANT Matilda Cathcart - 8430 Church Rd.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 										INTERVAL BETWEEN ONSET AND DEATH 3 days				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 				
20f. (City or town) (County) (State) 					20g. (City or town) (County) (State) 					20h. (City or town) (County) (State) 				
21. I certify that (I) (this hospital) attended the deceased from 8/21 , 19 67 , to 8/21 , 19 67 , that (I) (we) last saw the deceased alive on 8/21 , 19 67 , and that death occurred at 8:51 M. from the causes and on the date stated above.														
22a. SIGNATURE Brady Smith					22b. DATE SIGNED Aug. 22, 1967									
22c. PHYSICIAN'S NAME (Type) Brady Smith, M.D.					22d. ADDRESS Riviera Beach, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF Aug. 24, 1967					23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.				
23d. LOCATION (City, town or county) (State) Ritchie Hwy., A. A. Co., Md.					23e. REC'D BY REGISTRAR George J. Gonce					23f. REGISTRAR'S SIGNATURE Charles Judge				
24. FUNERAL DIRECTOR George J. Gonce - 4001 Ritchie Hwy., Baltimore					24a. ADDRESS 					24b. DATE AUG 28 1967				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10438

CERTIFICATE OF DEATH

10436

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>RURAL - ANNAPOLIS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SEVERN RIDGE ROAD</u>		e. STREET ADDRESS <u>SEVERN RIDGE ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>PETRONILLA</u> First Middle Last <u>CELUSTKA</u>		4. DATE OF DEATH Month <u>8</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8-1885</u> 9. AGE (in years last birthday) <u>82</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>PACOV. CHEZKOSLOVAKIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>VACLAV ZAJIC</u>		14. MOTHER'S MAIDEN NAME <u>PETRONILLA ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>FRANK J. CELUSTKA</u> Address <u>#2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Pneumonia</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I(c)) <u>Cerebral thrombosis (old), senility, decubitus ulcers</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 22, 1967</u> , to <u>August 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>August 22, 1967</u> , and that death occurred at <u>5:15 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Charles W. Kinzer</u> M.D.		22b. DATE SIGNED <u>August 23, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles W. Kinzer, M. D.</u>		22d. ADDRESS <u>16 Murray Ave., Annapolis, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>8-26-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WEEMS CREEK</u>	23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS A.A. MD.</u>
24. FUNERAL DIRECTOR <u>John M. Layton & Sons</u>		25a. REC'D BY REGISTRAR <u>August 28 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26

10

4

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10439

10437

1 PLACE OF DEATH a COUNTY <u>AA Co.</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>W. Va.</u> b COUNTY <u>✓</u>			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Harwood</u>				c LENGTH OF STAY in 1b <u>10 1/2</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA - Anne Arundel, Gen</u>				e STREET ADDRESS <u>Rt 1</u>			
3 NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>E</u> Last <u>Chaney</u>				4 DATE OF DEATH Month <u>8</u> Day <u>9</u> Year <u>1967</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH <u>January 21, 1906</u>		9 AGE (In years last birthday) <u>61</u> yrs		FUNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>contractor - builder general construction</u>				10b KIND OF BUSINESS OR INDUSTRY <u>Laurel Md</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Samuel Chaney</u>				14 MOTHER'S MAIDEN NAME <u>Alice May Whitehead</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <u>2-3-05-1949</u>				17 INFORMANT <u>Ellen Chaney Falling Waters W Va</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac disease</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> (Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.)				INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)			
20c TIME OF INJURY Month Day Year Hour <u> </u> am <u> </u> pm <u> </u> 19 <u> </u>		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>8-9-67</u>			
23a BURIAL, CREMATION, REMOVAL, (Specify)		23b DATE THEREOF <u>Aug 12, 1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>Calverton Naval Cem</u>		23d LOCATION (City or town) (County) (State) <u>Calverton Naval Md.</u>	
24 FUNERAL DIRECTOR <u>Charles Judge</u>				25a REC'D BY REGISTRAR <u>AUG 17 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
10440									
10438									
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Churchton c. LENGTH OF STAY IN b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Broadwater Parkway & Shore Dr.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Churchton d. STREET ADDRESS Broadwater Pkwy & Shore Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Harlan T Clark			4. DATE OF DEATH Month Day Year 8 8 1967						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-8-1884		9. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) Indiana			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Julia Clark			Address Same as 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver & pancreas 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 5 months	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 62 1962 to Aug 8 1967 , that (I) (we) last saw the deceased alive on Aug 8 1967 , and that death occurred at 5:30 AM, from the causes and on the date stated above.									
22a. SIGNATURE Willard F. Smith				22b. DATE SIGNED 8/8/67					
22c. PHYSICIAN'S NAME (Type) Willard F. Smith				22d. ADDRESS Shady Side, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-10-67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Prince George, Md.			
24. FUNERAL DIRECTOR Lee Funeral Home				ADDRESS Washington, D.C.		25a. REC'D BY REGISTRAR AUG 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10441

CERTIFICATE OF DEATH

10439

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 12 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel		d. STREET ADDRESS 261 Lake Rd.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last Roy N Cook Sr.		4. DATE OF DEATH Month Day Year 8 27 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-20-89
9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Automotive Eng.		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.	
11. BIRTHPLACE (County & State, or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stephen N. Cook		14. MOTHER'S MAIDEN NAME Mary J. Cook	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W. W. I		16. SOCIAL SECURITY NO 214-16-3704	
17. INFORMANT Mrs. Agnes D. Cook		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) neumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ASHD + Emphysema			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from August 15 , 19 67 , to August 27 , 19 67 , that (I) (we) lost saw the deceased alive on 8-27 , 1967, and that death occurred at 9:30 M, from causes on and on the date stated above.			
22a. SIGNATURE J. B. Ramirez		22b. DATE SIGNED 8/28/67	
22c. PHYSICIAN'S NAME (Type) Jorge B. Ramirez M.D.		22d. ADDRESS 3927 Annapolis Rd. Baltimore, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 31, 1967	23c. NAME OF CEMETERY OR CREMATORY Baltimore, National Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Hwy. (21225)	
25a. RECEIVED BY REGISTRAR SEP 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

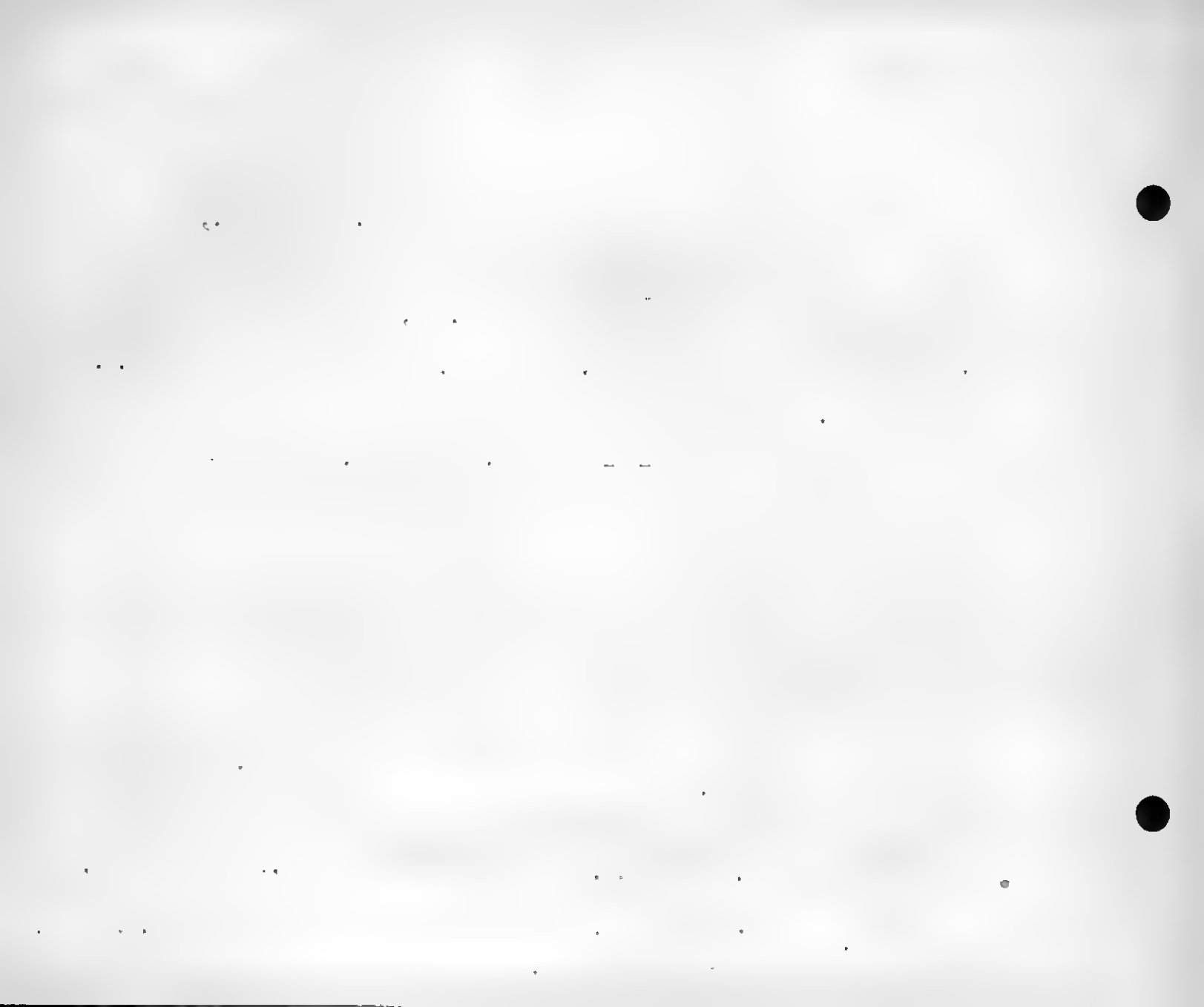
10442

CERTIFICATE OF DEATH

10440

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

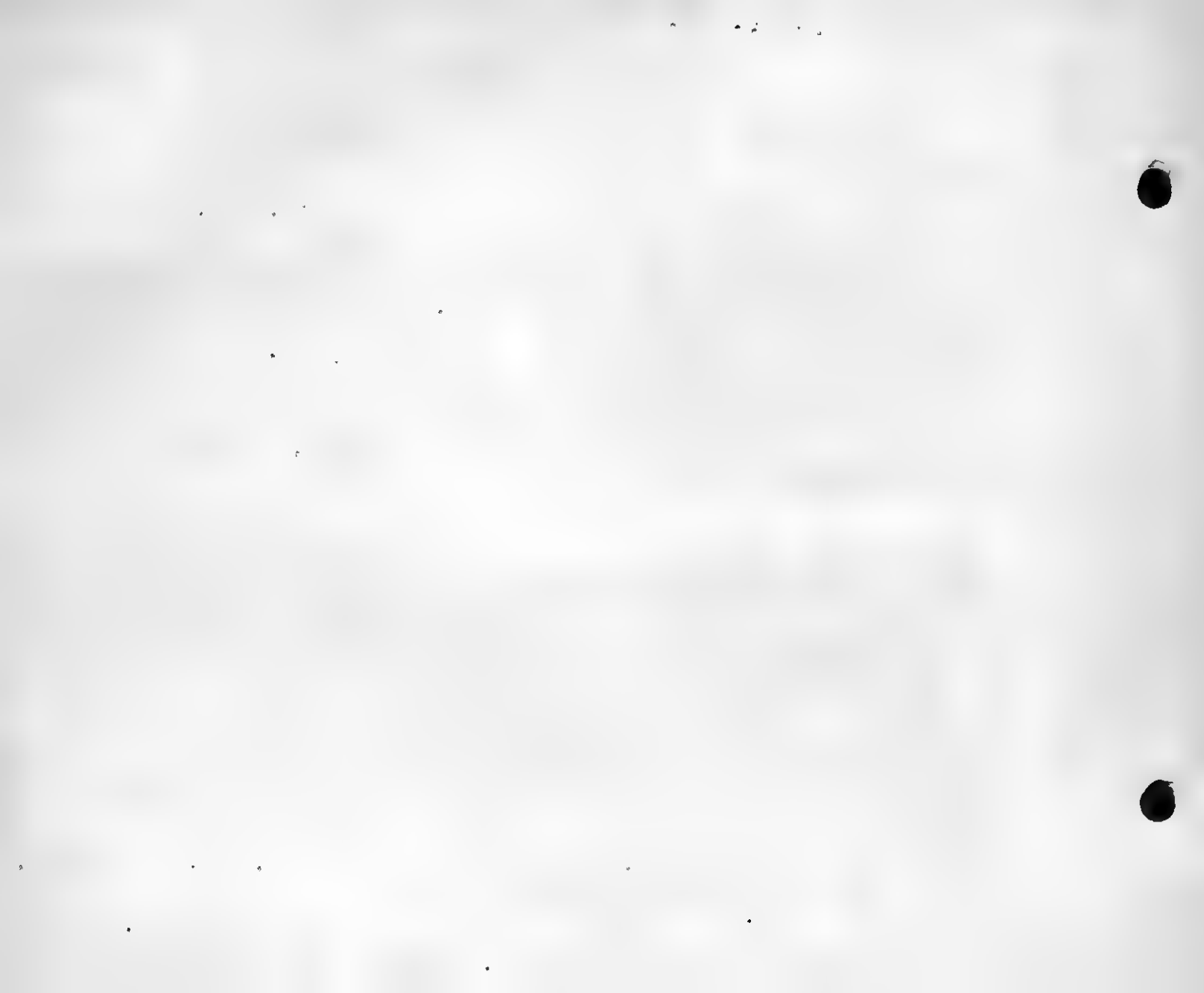
1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admiss on) a STATE Maryland b COUNTY Anne Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c LENGTH OF STAY IN tb Annapolis	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d STREET ADDRESS 26 N. Brewer Ave.,	
3 NAME OF DECEASED (Type or print) James Patrick COSTELLO		4 DATE OF DEATH Month August Day 12 Year 19 67	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 31, 1898
9 AGE (In years last birthday) 69 yrs.		10 IF UNDER 1 YEAR Months 12 Days 19 Hours 67 Min.	
11 BIRTHPLACE (County & State, or foreign country) St. Louis Missouri		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Michael J. Costello		14 MOTHER'S MAIDEN NAME Katherine Cleary	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) WW I		16 SOCIAL SECURITY NO 216-46-7052	
17 INFORMANT Mrs. Gertrude C. Costello - same as #2 above		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin's Disease - terminal pneumonia DUE TO (b) LUNG DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that (I) Robert O. Biern attended the deceased from May 1967 , to Aug. 12, 1967 , that (I) not last saw the deceased alive on Aug. 12, 19 67 , and that death occurred at 4:00 AM M, from causes and on the date stated above			
22a. SIGNATURE R. Biern		22b. DATESIGNED 8/12/67	
22c. PHYSICIAN'S NAME (Type) Robert O. Biern, M.D.		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 16, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Md.
24. FUNERAL DIRECTOR Hopping		25. REC'D BY REGISTRAR Charles Judge	
24b. ADDRESS HOPPING FUNERAL HOME - Annapolis, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE AUG 17 1967			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10443 CERTIFICATE OF DEATH 10441									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Knollwood Manor Nursing Home</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Percy</u> Middle <u>Cunningham</u> Last <u>Cunningham</u>					4. DATE OF DEATH Month <u>August</u> Day <u>9</u> Year <u>1967</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6 Feb. 1894</u>		9. AGE (in years last birthday) <u>73</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>AA County, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Thomas Cunningham</u>					14. MOTHER'S MAIDEN NAME <u>Annie Baker</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Anna H. Cunningham, same as 2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of prostate</u> 175 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinomatous</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 7, 1964</u> , to <u>Aug 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 7, 1967</u> , and that death occurred at <u>7:20 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert Dabolins</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Aug 11, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Robert Dabolins, M. D.</u>					22d. ADDRESS <u>400 Crain Hwy. N., Glen Burnie, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>12 Aug. 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		23d. LOCATION (City, town or county) (State) <u>Glen Burnie, Md.</u>		
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>					25a. REC'D BY REGISTRAR <u>Aug 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10644

10442

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MARGARETS</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BAY MANOR NURSING HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> d. STREET ADDRESS <u>713 GIDDINGS AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>WILLIAM G. CURRIER</u>		4. DATE OF DEATH <u>8 5 1967</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-12-1876</u>	9. AGE (In years last birthday) <u>90</u> yrs 10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Boston Mass</u>
13. FATHER'S NAME <u>ALFRED H. CURRIER</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE FOGG</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>ALBERT E. CURRIER</u> Address <u>#2</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>3/9 1966</u> to <u>8/5 1967</u> that (I) (we) last saw the deceased alive on <u>7/20 1967</u> and that death occurred at <u>3:20 M.</u> from the causes and on the date stated above				
22a. SIGNATURE <u>Richard E. Hoxham</u>		22b. DATE SIGNED <u>8/5/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Richard E. Hoxham</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>8-7-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FL. LINCOLN</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. G. Fox</u>		24b. ADDRESS <u>Annapolis, Md.</u>		24a. LOCATION (City, town or county) (State) <u>ANNAPOLIS MD.</u>
25a. REC'D BY REGISTRAR <u>AUG 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

10445

CERTIFICATE OF DEATH

10443

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Harford	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 9 mos. 4 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e STREET ADDRESS 1111 N. Bentalou St.	
3. NAME OF DECEASED (Type or print) 3-#10760 Rosa Cromwell Daugherty		4. DATE OF DEATH Month 8 Day 21 Year 1967	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1898
9 AGE (In years last birthday) 69 yrs		10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Domestic	
10b KIND OF BUSINESS OR INDUSTRY -----		11 BIRTHPLACE (County & State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Henry A. Cromwell	
14 MOTHER'S MAIDEN NAME Mary F.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia-Hypostatic DUE TO (b) Cerebro-vascular accident (Cerebral thrombosis) DUE TO (c) Hypertensive arteriosclerotic cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -----	
20c TIME OF INJURY Month, Day, Year Hour "o.m." --- 19 --- p.m. ---	20d INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f (City or town) (County) (State) -----
21. I certify that (I) (this hospital) attended the deceased from 11/17 , 19 47 , to 8/21 , 1967, that (I) (we) last saw the deceased alive on 8/21 , 1967, and that death occurred at 10:30 A. from causes and on the date stated above			
22a SIGNATURE <i>Lionel McHenry Mapp</i>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		22d ADDRESS Crownsville State Hospital, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Sept. 1, 1967	23c NAME OF CEMETERY OR CREMATORY John Wesley Cemetery	23d LOCATION (City or Town) (County) (State) Abingdon Harford Md
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.		25a REC'D BY REGISTRAR DATE SEP 5 1967	
		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10446

CERTIFICATE OF DEATH

10444

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		c. LENGTH OF STAY IN 16 8 mos.	
d. NAME OF HOSPITAL, DR INSTITUTION (If not in hospital, give street address) Knollwood Nursing Home		d. STREET ADDRESS Rt. 1 Box - 323	
3 NAME OF DECEASED (Type or print) Bernadine		4 DATE OF DEATH Month August Day 14 Year 19 67	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 18 June 1892
10a USUAL OCCUPATION (Give kind of work done during most of work on life, even if retired) Homemaker		10b KIND OF BUSINESS OR INDUSTRY Own Home	11 BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
13 FATHER'S NAME Leo Thielke		14 MOTHER'S MAIDEN NAME (Unknown)	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO NONE	17 INFORMANT Laurence S. Davis, Same as # 2
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of colon DUE TO (c) 1 year			INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic secondary to above			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov. 15 , 19 66 , to Aug. 14 , 19 67 , that (I) (we) last saw the deceased alive on July 5 , 19 67 , and that death occurred at 12:15 A.M. from causes and on the date stated above			
22a. SIGNATURE Rm Smith		22b. DATE SIGNED 8/14/67	
22c. PHYSICIAN'S NAME (Type) Ray M. Smith, M. D.		22d. ADDRESS Hahn Professional Bldg., Severna Pk., Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 16 Aug 1967	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.	23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland
24. FUNERAL DIRECTOR Robert Pappas		25a. REC'D BY REGISTRAR DATE AUG 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME Charles Judge	

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10447

CERTIFICATE OF DEATH

10445

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Ann Arundel 	
b. CITY OR TOWN (If outside corporate limits, write RURAL or Green Haven) Green Haven		c. LENGTH OF STAY in lb 14 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital		d. STREET ADDRESS Box 378, East Shore Rd.	
3. NAME OF DECEASED (Type or print) Olga Mae Davis		4. DATE OF DEATH Aug. 28, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-2-03
9. AGE (In years and ⁶⁴ birthday) yrs 64		10. IF UNDER 1 YEAR Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Yatesville Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Burch Hewitt		14. MOTHER'S MAIDEN NAME Natie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Irma Mae Lambert		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Obstructive jaundice secondary to inoperable carcinoma pancreas DUE TO (b) liver failure DUE TO (c) liver failure Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 16 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug. 12, 1967 to 8/28 , 1967, that (I) (we) last saw the deceased alive on Aug. 26 , 1967, and that death occurred at 12:04 P.M. from causes and on the date stated above.			
22a. SIGNATURE Arsenio Santos		22b. DATE SIGNED 8.28.67	
22c. PHYSICIAN'S NAME (Type) ARSENIO SANTOS MD		22d. ADDRESS 3350 Wilkes Ave. Baltimore MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 1, 1967	23c. NAME OF CEMETERY OR CREMATORY Atkins Fam. Cemetery	23d. LOCATION (City or Town) (County) (State) Louisa, Kentucky
24. FUNERAL DIRECTOR George J. Gonce		25. REC'D BY REGISTRAR SEP 1 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10448

10446

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Washington, D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 3736 Camden St., S.E.	
3 NAME OF DECEASED (Type or print) First Middle Last GEORGE F DONNELLA		4 DATE OF DEATH Month Day Year August 13, 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 22 Sept 1942
9 AGE (In years lost birthday) 25 2/4		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Apprentice Plumber		10b KIND OF BUSINESS OR INDUSTRY I Plumbering	
11 BIRTHPLACE (State or foreign country) Washington, D.C.		12 CITIZEN OF WHAT COUNTRY U.S.A.	
13 FATHER'S NAME George F. Donnelly		14 MOTHER'S MAIDEN NAME G. Eloise Lingebach	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No No		16 SOCIAL SECURITY NO.	
17 INFORMANT George F. Donnelly		Address 3736 Camden st S E	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Injuries 8.214 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) DUE TO			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRINCIPAL OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Subj. driver of motorcycle - ran off roadway - struck stump - subj. thrown.	
20c TIME OF INJURY Month, Day, Year Hour am pm 12 xx 8/13 19 67		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Street		20f (City or town) (County) (State) Anne Arundel, Md.	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED 8/14/67			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 8.16.67	
23c NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		23d LOCATION (City or Town) (County) (State) Washington D C.	
24. FUNERAL DIRECTOR Lee Funeral Home 300.4th st N E		25a REGD BY REGISTRAR DATE Aug 16 1967	
		25b REGISTRAR'S SIGNATURE Judge	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

10449

10447

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD</u> b COUNTY <u></u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>		c LENGTH OF STAY IN 1b <u>1922 Drivill Hill Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Laurel Infirmary</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>John J. Dowery</u>		4 DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years last birthday) <u>62</u> yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Crest Construction - Washington D.C.</u>	
11 BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Dowery</u>		14 MOTHER'S MAIDEN NAME <u>Sarah E. Howard</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>216-01-3603</u>	
17 INFORMANT <u>Arbutus F. Moore -1413 E. Capital St.</u>		Address <u>Wash. D.C.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>Cornary Thrombosis (acute)</u> 4201 DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Albert L. Anderson</u>		22. DATE SIGNED <u>8/28/67</u>	
EXAMINER'S NAME (Type) <u>ALBERT L. ANDERSON</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b DATE THEREOF <u>9/2/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Sutland Maryland</u>	
24 FUNERAL DIRECTOR <u>Carlton J. Utter -3035 W. North Ave.</u>		25a REC'D BY REGISTRAR DATE <u>AUG 31 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10450

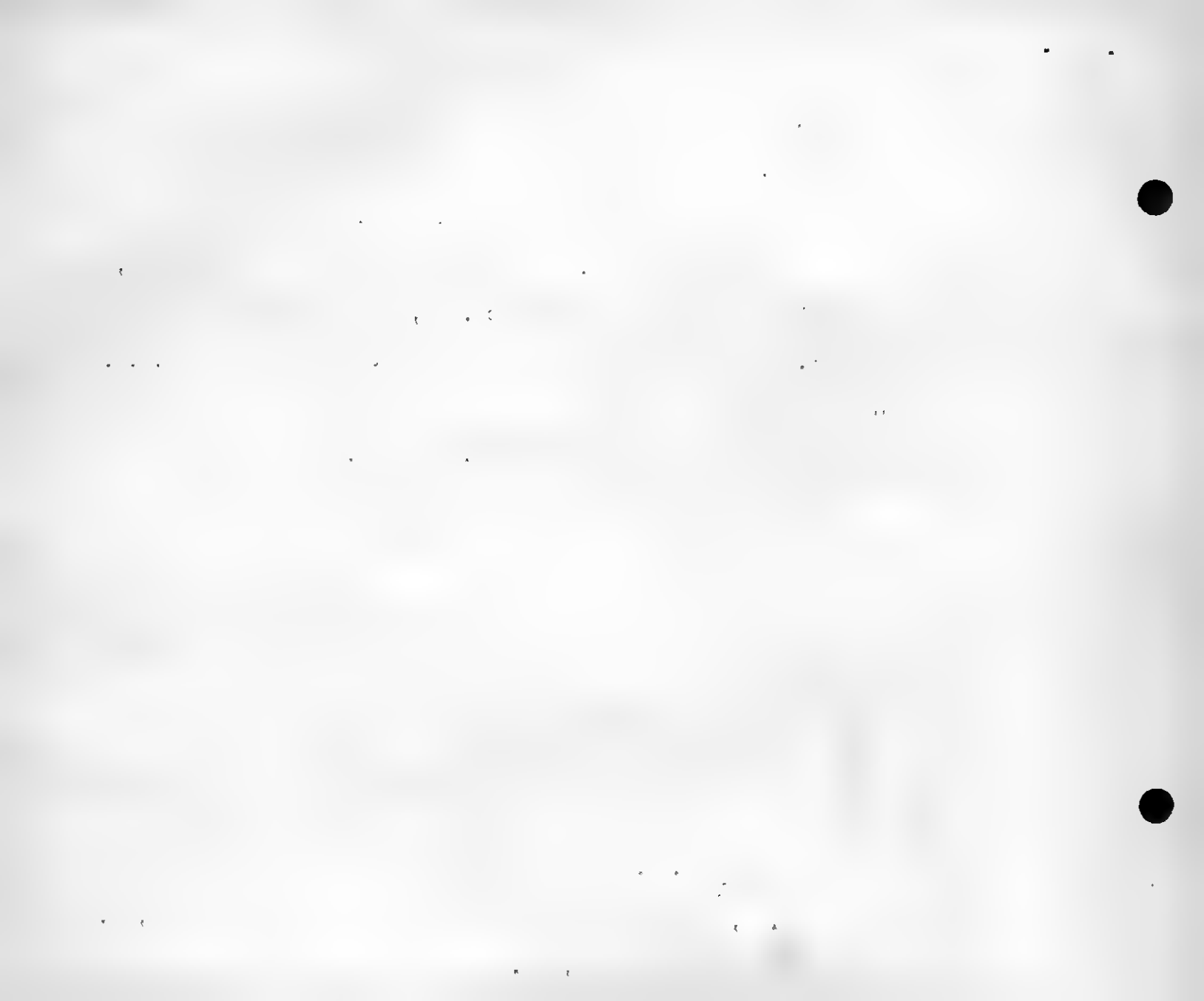
CERTIFICATE OF DEATH

10448

1 PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville c. LENGTH OF STAY IN b. 16 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Knollwood Manor Nursing Home		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville d. STREET ADDRESS Box #200-A e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First ALONZO Middle J. Last EFFLAND		4. DATE OF DEATH Month August Day 3 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1901
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard (ret.)		10b. KIND OF BUSINESS OR INDUSTRY State of Maryland	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown (Effland)		14. MOTHER'S MAIDEN NAME (Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 705-14-2397	
17. INFORMANT Mrs. Beula M. Effland (wife)		Address Same As #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Consecutive heart failure DUE TO (c) Anemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis Chronic			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 10 , 19 67 , to Aug 3 , 19 67 , that (I) (we) lost saw the deceased alive on Aug 3 , 19 67 , and that death occurred at 250 PM , from causes and on the date stated above.			
22a. SIGNATURE Ray M. Smith		22b. DATE SIGNED Aug. 4, 1967	
22c. PHYSICIAN'S NAME (Type) Ray M. Smith M. D.		22d. ADDRESS Hahn Professional Building, Severna Park Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 7, 1967	23c. NAME OF CEMETERY OR CREMATORY Snyder's Chapel Cemetery	23d. LOCATION (City or Town) (County) (State) Morgan County, W. Virginia
24. FUNERAL DIRECTOR R. J. Singley		25a. REC'D BY REGISTRAR Glen Burnie, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE AUG 7 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1, 2, and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



10451

CERTIFICATE OF DEATH

10449

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the burial papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDLESEX</u>		c. LENGTH OF STAY IN 1b <u>3 WKS.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KNOLLWOOD MANOR CONVALESCENT HOME</u>		d. STREET ADDRESS <u>ROUTE 3 BOX 316</u>	
3 NAME OF DECEASED (Type or print) <u>LUIGI ERCOLI</u>		4 DATE OF DEATH Month <u>AUGUST</u> Day <u>12</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>MAY 20, 1891</u>
9. AGE (in years last birthday) <u>76</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONCRETE CORP.</u>	11 BIRTHPLACE (County & State, or foreign country) <u>ITALY</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>UNKNOWN</u>	
14 MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16 SOCIAL SECURITY NO <u>UNKNOWN</u>		17 INFORMANT <u>CARL M. ERCOLI SAME AS #2</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral vascular insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/10, 1967</u> to <u>8/12, 1967</u> , that (I) (we) last saw the deceased alive on <u>7/28, 1967</u> , and that death occurred at <u>11:00 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Richard I. Hochman</u>		22b. DATE SIGNED <u>8/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>		22d. ADDRESS <u>16 Murray Avenue, Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8/16/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>	23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON, D.C.</u>
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS CO. INC.</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



10452

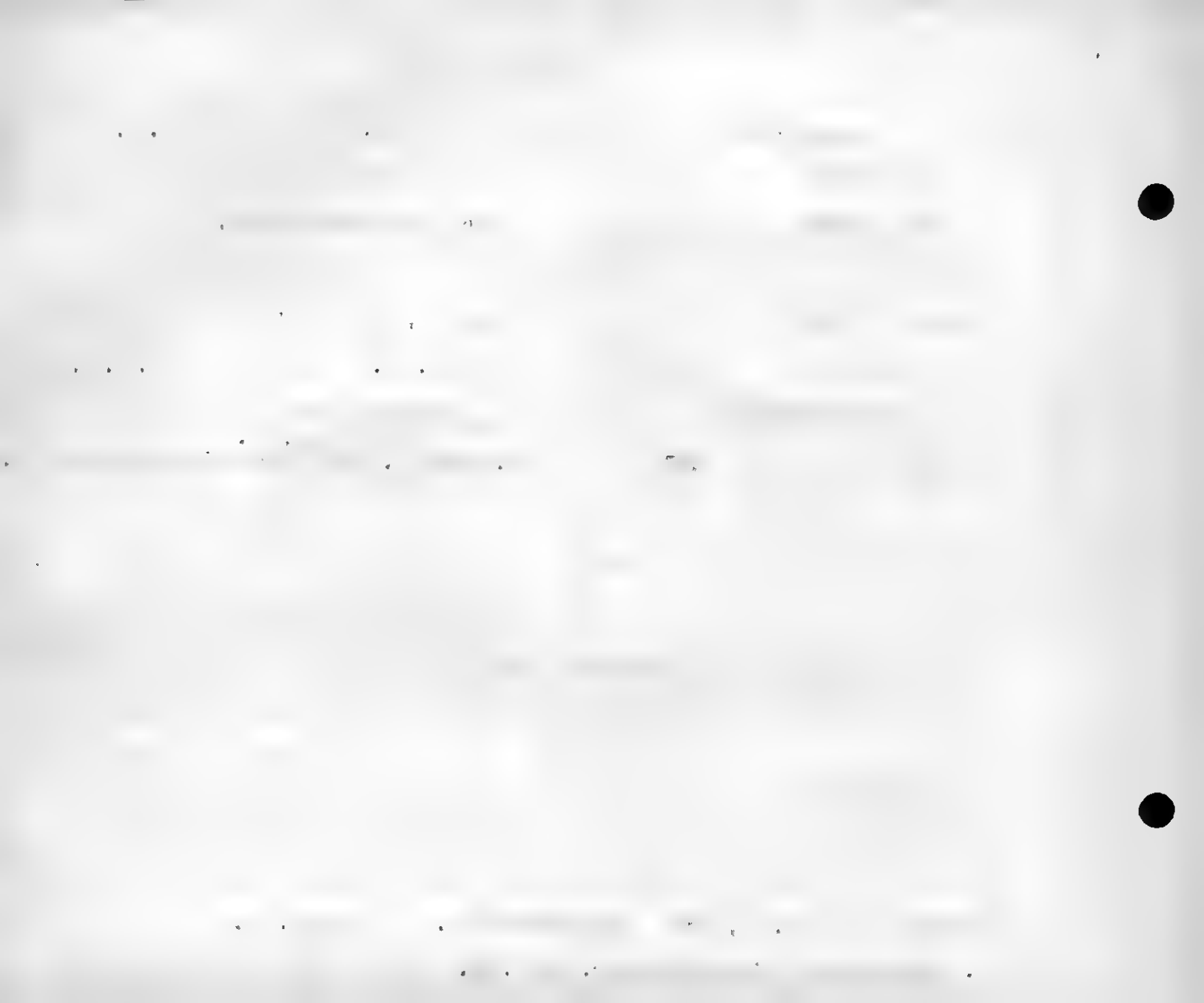
CERTIFICATE OF DEATH

10450

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY A. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Burnie		c. LENGTH OF STAY IN 1b Glenn Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel		d. STREET ADDRESS Box 460 Quarterfield Rd.	
3 NAME OF DECEASED (Type or print) FRANCES E. Eschrich		4 DATE OF DEATH Aug. 11, 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 14, 1917
9 AGE (In years last birthday) 50 yrs.		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress	
10b KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (County & State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Patrick McDermott	
14. MOTHER'S MAIDEN NAME Brigitte Parson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 221		17. INFORMANT Glenn Burnie, Md. Address Mr. George J. Eschrich Box 460 Quarterfield Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Vascular Disease DUE TO Hypertension & Arteriosclerosis DUE TO Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 3-4 weeks 4-6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 9	
20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 8/10, 1967 , to 8/10, 1967 , that (I) (we) last saw the deceased alive on 8/10 , and that death occurred at 10 M, from causes on and the date stated above	
22a. SIGNATURE Chas. K. Ball		22b. DATE SIGNED 8/17/67	
22c. PHYSICIAN'S NAME (Type) Luthicus 3rd		22d. ADDRESS Luthicus 3rd	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Aug. 14, 1967	
23c NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d LOCATION (City or Town) (County) (State) Balto. Md.	
24 FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave. Balto. Md.		25a REC'D BY REGISTRAR AUG 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10453

CERTIFICATE OF DEATH

10451

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 3 mos	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Richard Flavin		4. DATE OF DEATH Month 8 Day 23 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/7/1900
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Shomokin, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Flavin		14. MOTHER'S MAIDEN NAME Annie McGhee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 8/42 2/48		16. SOCIAL SECURITY NO 217-16-6153	
17. INFORMANT Hospital Records, Crownsville, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchogenic Carcinoma of right lung with metastasis to brain, adrenal and lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of rectum (resected); alcoholism		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/19 , 19 67 , to 8/23 , 19 67 , that (I) (we) last saw the deceased alive on 8/23/67 , 19 67 , and that death occurred at 5/28 PM , from causes and on the date stated above.			
22a. SIGNATURE C. Dorkan, M.D.		22b. DATE SIGNED 8/24/67	
22c. PHYSICIAN'S NAME (Type) C. Dorkan, M.D.		22d. ADDRESS Crownsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 8/26/67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR John A. Moran, Inc. 3000 J. Baltimore St.		25a. REC'D BY REGISTRAR AUG 28 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WILD ROSE SHORES</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNAPOLIS NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frances Toohy Ford</u>		4. DATE OF DEATH Month <u>8</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-1898</u>
9. AGE (In years last birthday) <u>69</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARER</u>	
11. BIRTHPLACE (County & State or foreign country) <u>N.Y. City N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN TOOHEY</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET COURTNEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>072 22 2681</u>	
17. INFORMANT <u>MRS. JOHN J. LAUSCH</u>		Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Resumet syndrome of 3rd ventricle</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 196 <u>5</u> , to <u>August</u> , 196 <u>7</u> , that (I) (we) last saw the deceased alive on <u>8/12</u> , 196 <u>7</u> , and that death occurred at <u>3:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John Hederman</u>		22b. DATE SIGNED <u>8/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN HEDERMAN</u>		22d. ADDRESS <u>FOREST DR. ANNAPOLIS MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8-16-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARYS</u>	23d. LOCATION (City or town) (County) (State) <u>ANNAPOLIS MD.</u>
24. FUNERAL DIRECTOR <u>John M. Layton & Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>John M. Layton & Sons</u>	
25b. REGISTRAR'S SIGNATURE <u>John M. Layton & Sons</u>		DATE <u>AUG 16 1967</u>	

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
GM 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10455

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10453

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.C.A. General</u>		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) <u>Calvin Forrester</u>		4 DATE OF DEATH Month <u>8</u> - Day <u>6</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Col</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (in years last birthday) <u>11-4-1937</u> yrs
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>	
10a. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Thomas Forrester</u>		14 MOTHER'S MAIDEN NAME <u>Mary B. Foote</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>216328527</u>	
17 INFORMANT <u>Thomas Forrester</u>		Address <u>Chillum</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY			
IMMEDIATE CAUSE (a) <u>Drowning</u>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
DUE TO			
DUE TO			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTR BUT NOT CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell out of moving boat</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>8/6</u> PM <u>1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home farm factory, street, office, bldg, etc.) <u>Whit Lane</u>		20f. (City or town) (County) (State) <u>P.A.C. MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Forrester</u>		22. DATE SIGNED <u>8/6/67</u>	
EXAMINER'S NAME (Type) <u>E. L. Forrester</u>		M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>8-10-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Charmichael</u>		23d. LOCATION (City or town) (County) (State) <u>Owensville MD</u>	
24. FUNERAL DIRECTOR <u>William Reese #</u>		25a. RECD BY REGISTRAR <u>AUG 8 1967</u>	
ADDRESS <u>Chillum</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE
HEALTH DEPT.

10456

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10454

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN MD <u>Annapolis</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A. A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>7- Hicks Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leon</u> First <u>Fountain</u> Middle <u>Fountain</u> Last <u>Fountain</u>		4. DATE OF DEATH Month <u>8</u> - Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-1924</u> 4-2 yrs
9. AGE (In years last birthday) <u>42</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leon Fountain</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Waves</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>2460 X</u>	
17. INFORMANT <u>Sharon Fountain - Balto. Md.</u>		Address <u>Balto. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> DUE TO <u>Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis</u> (c) <u>Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sharon</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>260 X</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. W. Baker</u> M.D.		22. DATE SIGNED <u>8/16/67</u>	
EXAMINER'S NAME (Type) <u>E. L. W. Baker</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town or county)		Address (Street, city, town or county)	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-21-1967</u>	23c. NAME OF EMPLOYER OR CREMATOR <u>Balto. National</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto. MD</u>
24. FUNERAL DIRECTOR <u>William Reese #1</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>AUG 21 1967</u>	
ADDRESS <u>Annapolis</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10455

10455

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>AA CO</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>MD</u> b COUNTY <u>AA CO</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c LENGTH OF STAY in 15 <u>1 Pasadena A -</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D. A. North. Howard. Hosp.</u>		d STREET ADDRESS <u>220 Glenland Beach Rd</u>	
3 NAME OF DECEASED (Type or print) First <u>EARL</u> Middle <u>G</u> Last <u>Geoghegan</u>		4 DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-27-13</u>
9 AGE (in years last birthday) <u>54</u> yrs		10 F UNDER 1 YEAR Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min <u>18</u>	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coppersmith</u>		11b KIND OF BUSINESS OR INDUSTRY <u>Met. Steel Co.</u>	
11 BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Augustus S. Geoghegan</u>		14. MOTHER'S MAIDEN NAME <u>Grace Cook</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOC. A. SECURITY NO. <u>Same</u>	
17 INFORMANT <u>Mrs. Helen D. Geoghegan</u>		Address <u>Same</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>intermedullary</u> DUE TO <u>260X</u> (b) <u>Chronic myeloid</u> DUE TO (c) <u>leukemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>leukemia</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above and an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		22. DATE SIGNED <u>8/18/67</u>	
EXAMINER'S NAME (Type) <u>E. L. [Signature]</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>8 22 67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>	23d LOCATION (City or Town) (County) (State) <u>Glen Burnie, A. A. Co., Md.</u>
24. FUNERAL DIRECTOR <u>Mc Cully 130 E. Fort Ave</u>		25a REC'D BY REGISTRAR <u>DATE AUG 21 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10458

1. PLACE OF DEATH
a. COUNTY ANNE ARUNDEL MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MILLERSVILLE

c. LENGTH OF STAY IN 18 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Knollwood Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY Howard

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ELK RIDGE

d. STREET ADDRESS Box B-8 6808 Wash. Blvd.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First SALLIE Middle L Last GRAHAM

4. DATE OF DEATH
Month Aug Day 29 Year 1967

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH May 21/1886 9. AGE (In years last birthday) 81 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (County & State, or foreign country) Roanoke Co. Va. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Cooper 14. MOTHER'S MAIDEN NAME Sarah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN 16. SOCIAL SECURITY NO. 265-03305 17. INFORMANT Dorsey C. Graham Address 6808 Wash. Blvd. Elkridge

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 4341 DUE TO Left ventricular failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Acute Pulmonary edema
Congestive Heart Failure (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While ☐ Not While ☐ at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/11, 1967 to 8/29, 1967 that (I) (we) last saw the deceased alive on 8/29, 1967, and that death occurred at 4 A.M. from the causes and on the date stated above.

22a. SIGNATURE Max C Frank M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 8/29/67

22c. PHYSICIAN'S NAME (Type) MAX C FRANK 22d. ADDRESS 425 SE Ritchie Hwy Glen Burnie Md 21061

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9/1/67 23c. NAME OF CEMETERY OR CREMATORY St. Andrew's Cem. 23d. LOCATION (City, town or county) Roanoke Co., Va.

24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Brooks, Inc. ADDRESS 1217 st. Paul St. Balto. 25a. REC'D BY REGISTRAR AUG 31 1967 25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10457

CERTIFICATE OF DEATH

10458 Items 17, 23a, 23b, 23c & 23d Telephone call Singleton F. H. 3/21/67

1. PLACE OF BIRTH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Annapolis Convalescent Center		d. STREET ADDRESS 204 Fenwick Ave. Fenwick	
3. NAME OF DECEASED (Type or print) First CARL Middle S Last GRAY		4. DATE OF DEATH Month Aug Day 28 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 12/20/1911
9. AGE (In years last birthday) 55 yrs		10. IF UNDER 1 YEAR Months 1 Days 28 Hours 15 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		12. KIND OF BUSINESS OR INDUSTRY United Pump	
13. FATHER'S NAME Charles A. Gray		14. BIRTHPLACE (County & State, or foreign country) Jonesport, Marie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 067-05-5785	
17. INFORMANT Mrs. Thelma Gray (wife)		18. ADDRESS Sara - s 42	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Left ventricular failure DUE TO (b) Carcinomatous Generalized DUE TO (c) Carcinoma of lung		INTERVAL BETWEEN ONSET AND DEATH Months	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, essential		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 23/ 1967 to Aug 28, 1967 that (I) (we) last saw the deceased alive on Aug 28 1967 , and that death occurred at 120 A M. from causes and on the date stated above.			
22a. SIGNATURE Max C Frank MD		22b. DATE SIGNED 8/28/67	
22c. PHYSICIAN'S NAME (Type) MAX C FRANK MD		22d. ADDRESS 425 SE Ritchie Hwy - Glen Burnie MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-31-67	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park	23d. LOCATION (City or Town) (County) (State) Glen Burnie, An. Ar., Md.
24. FUNERAL DIRECTOR R. J. Singleton, Funeral Home, H. O'Hanlon		25a. REC'D BY REGISTRAR DATE AUG 30 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10458

10460

1 PLACE OF DEATH a. COUNTY <u>An. A.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>An. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>163 Obery Court</u>		d. STREET ADDRESS <u>163 Obery Ct</u>	
3. NAME OF DECEASED (Type or print) <u>Susan</u> First Middle Last		4. DATE OF DEATH Month <u>8</u> Day <u>-10</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-17-1888</u>
9. AGE (In years last birthday) <u>87</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, except ret. rep.) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Phillip Dindell</u>		14. MOTHER'S MAIDEN NAME <u>Elenora Randall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Gene E. Spencer</u>		Address <u>163 Obery Ct</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Hypertensive Cardio Vascular</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Disease</u> DUE TO (c) <u>Senal Dementia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1</u> , 19 <u>67</u> , to <u>Aug. 10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug. 10</u> , 19 <u>67</u> , and that death occurred at <u>830A</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>R. L. Richardson</u>		22b. DATE SIGNED <u>8-10-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. L. Richardson, M.D.</u>		22d. ADDRESS <u>110 Clay St., Annapolis, Md., 21401</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-13-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Annapolis Md.</u>
24. FUNERAL DIRECTOR <u>William Beese</u>		25a. REC'D BY REGISTRAR <u>Aug 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10461

CERTIFICATE OF DEATH

10459

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEO G MEADE		c. LENGTH OF STAY IN 1b 1 Day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SAVAGE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		d. STREET ADDRESS 101 WILLIAM STREET	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First HELEN Middle R. Last HAGAN		4 DATE OF DEATH Month AUGUST Day 17 Year 19 67	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3 JAN 1913
9 AGE (In years last birthday) 54 yrs		10 IF UNDER 1 YEAR Months 17 Days 19 Hours 67 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11 BIRTHPLACE (County & State, or foreign country) Savage, Howard, Md
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Leroy Conaway	
14. MOTHER'S MAIDEN NAME Dora Junkins		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No N/A	
16. SOCIAL SECURITY NO None		17 INFORMANT Frank Hagan, 101 William St, Savage, Md	
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Resp Acidosis & Bronchto Pneumonia DUE TO (b) Bronchitis & Emphysema DUE TO (c) None		INTERVAL BETWEEN ONSET AND DEATH Days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that it (this hospital) attended the deceased from 16 Aug , 1967, to 17 Aug , 1967, that it (we) last saw the deceased alive on 17 Aug , 1967, and that death occurred at 4:55 a.m. , from causes and on the date stated above.			
22a SIGNATURE Harold W. Draper, Maj. M.C. M.D.		22b. DATE SIGNED 17 Aug 1967	
22c. PHYSICIAN'S NAME (Type) HAROLD W. DRAPER, MAJOR, MC		22d ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 8/21/67	23c NAME OF CEMETERY OR CREMATORY Baltimore Natl Cem Baltimore Md	23d LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR Walter Donaldson		25a. REC'D BY REGISTRAR DATE AUG 22 1967	25b REGISTRAR'S SIGNATURE J. Charles Jones

10462

CERTIFICATE OF DEATH

10460

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an. Residence before adm.ssion) a. STATE <u>Maryland</u> b. COUNTY <u></u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>1 year 5 mon.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>4058 Hickory Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Raymond J. Hammett</u>		4. DATE OF DEATH Month <u>8</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/9/1890</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		9. AGE (In years last birthday) <u>77</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Edmond Hammett</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. MOTHER'S MAIDEN NAME <u>ELLA Davis</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>	
16. SOCIAL SECURITY NO. <u>219-54-3587</u>		17. INFORMANT <u>Hospital Records, Crownsville, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Chronic Brain Syndrome associated with generalized arteriosclerosis.</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4500</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>41</u> (this hospital) attended the deceased from <u>3/6</u> , 19 <u>66</u> , to <u>8/4</u> , 19 <u>67</u> , that <u>41</u> (we) last saw the deceased alive on <u>8/4</u> , 19 <u>67</u> , and that death occurred at <u>1:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>L. Benedict, M. D.</u>		22b. DATE SIGNED <u>8/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>		22d. ADDRESS <u>Crownsville Maryland 21032</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>8-7-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Ridge Md.</u>
24. FUNERAL DIRECTOR <u>John M. Welch</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 8 1967</u>	

10463

CERTIFICATE OF DEATH

10461

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>Linthicum</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d. STREET ADDRESS <u>109 Orchard Road</u>	
3. NAME OF DECEASED (Type or print) <u>Florence Harvatt</u>		4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-15-71</u>
9. AGE (In years lost birthday) <u>96 yrs</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Packing House</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland (American waters)</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Rytell</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>215-28-8286</u>	
17. INFORMANT <u>Martha A. Tepper</u>		Address <u>109 N. Orchard St 21090</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>① CVA</u> DUE TO <u>201X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>② arteriosclerosis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ASHD</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>67</u> , to <u>8/20</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8/20/67</u> 19 <u> </u> , and that death occurred at <u>3:30 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>J.B. Ramirez</u>		22b. DATE SIGNED <u>8/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J.B. RAMIREZ</u>		22d. ADDRESS <u>3927 ANNA POLIS RD Balto Md</u> <u>1672 NORTH BOURNE RD Balto Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug 24, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross PNC cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>German Hill Rd. Balto Md.</u>
24. FUNERAL DIRECTOR <u>Dippel Brothers Inc. 1800 E. Lombard St. Balto</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 25 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

10462

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Ann Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ann Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		d. STREET ADDRESS <u>110 Louise Drive</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>110 Louise Dr.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sadie</u> First <u>H</u> Middle <u>Hayes</u> Last				4. DATE OF DEATH <u>August 24</u> 19 <u>67</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 5, 1895</u> 72 yrs.	
9. AGE (If years lost birthday) <u>72</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Perry Hayes</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Hayes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-54167</u>		17. INFORMANT <u>Henrietta Hayes</u> Address <u>110 Louise Dr. Ann</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>							
DUE TO (b) <u>Hypertensive Cardiovascular Disease</u>							
DUE TO (c) <u>3 was</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 <u>5-24-67</u> Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>5-24-67</u> , 19 <u>67</u> to <u>8-24-67</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>5-24-67</u> , 19 <u>67</u> , and that death occurred at <u>6:45</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ann T. Allen</u> M.D. <u>62</u>				DATE SIGNED <u>8-28-67</u>			
PHYSICIAN'S NAME (Type) <u>ARIS T ALLEN</u> <u>Annapolis Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/29/67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Broad Neck Meth. Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Broad Neck Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Johnson</u> ADDRESS <u>844 West St. Ann</u>				24a. REC'D BY REGISTRAR <u>16 31 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10465

CERTIFICATE OF DEATH

10463

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, nearest town) Annapolis		c. LENGTH OF STAY IN 1b	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Baltimore		d. STREET ADDRESS 3125 Betlou James Place	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Frank Middle F. Last Higgs		4 DATE OF DEATH Month August Day 27 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 24, 1924
9 AGE (In years last birthday) 43 yrs		IF UNDER 1 YEAR Months 24 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done (If no most of working life, even if retired)) Heavy Equipment Operator Co. Sanitation		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME William Higgs		14. MOTHER'S MAIDEN NAME Sarah Howard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218-18-7858	
17 INFORMANT Mrs. Mary K. Higgs		3125 Betlou James Place Balto Md. 21207	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 HR. 14 MOS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)	21. I certify that (I) (this hospital) attended the deceased from JUNE 23, 1966 , to AUG. 27, 1967 , that (I) (we) last saw the deceased alive on AUG. 3, 1967 , and that death occurred at 8 P. M. , from causes and on the date stated above.	
22a. SIGNATURE Marvin Goldstein	M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 8/29/67
22c. PHYSICIAN'S NAME (Type) Marvin Goldstein, M.D.	22d. ADDRESS 6001 Park Heights Ave Balto Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/31/67	23c. NAME OF CEMETERY OR CREMATORY Lorraine
23d. LOCATION (City or Town) (County) (State) Woodlawn, Balto Md.	24. FUNERAL DIRECTOR Spring Bzow 8728 Liberty Rd Randallstown Md	
25a. REC'D BY REGISTRAR AUG 30 1967	25b. REGISTRAR'S SIGNATURE Charles Yunge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Page 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
10466					10464				
1. PLACE OF DEATH a. COUNTY A A Co					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY AA Co				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Gen Hosp					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First James Middle H Last Hood Jr					4. DATE OF DEATH Month Aug Day 20 Year 19 67				
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/7/06		9. AGE (In years last birthday) 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Body Fender				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James H Hood Sr					14. MOTHER'S MAIDEN NAME Unk				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7201 Coronary Thrombosis DUE TO (b) Coronary Sclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH Immediate 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/7, 1967 , to 8/20, 1967 , that (I) (we) last saw the deceased alive on 8/19, 1967 , and that death occurred at M , from the causes and on the date stated above.									
22a. SIGNATURE J. Brady Smith					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/21/67		
22c. PHYSICIAN'S NAME (Type) J. BRADY SMITH					22d. ADDRESS PASADENA, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 8/24/67		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem		23d. LOCATION (City, town or county) (State) Balto Co		
24. FUNERAL DIRECTOR McCully F H 237 Patapsco Ave 21225					25a. REC'D BY REGISTRAR DATE AUG 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

10467

CERTIFICATE OF DEATH

10465

1 PLACE OF DEATH a COUNTY Anne Arundel		b MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland		b COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c LENGTH OF STAY IN TB 29 days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital				d. STREET ADDRESS 338 Oella Ave.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Christine		First B.		Middle Howard		Last Aug. 21 1967	
5. SEX Female		6 COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 2-5-01	
9 AGE (In years lost birthday) 66		IF UNDER 1 YEAR Months Days Hours Min.		11 BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		13 FATHER'S NAME William H. Brown		14. MOTHER'S MAIDEN NAME Louphonie Jenkins	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Annie Matthews		Address 409 Oella Ave. Balt., Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4-00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) CVA ASHD							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c TIME OF INJURY Month, Day, Year Hour am p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/6/67 , 19 67 to 8/21 , 19 67 that (I) (we) last saw the deceased alive on 8/20/67 , and that death occurred at 11:30 M, from causes and on the date stated above							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
22a SIGNATURE Dr. Jorge Ramirez		22b. DATE SIGNED 8/21/67		22c. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22d. ADDRESS 3927 ANNA POLIS RD Baltimore 21204 1612 NORTHBURN RD Baltimore 21204	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 8-23-67		23c. NAME OF CEMETERY OR CREMATORY Baltimore, Md.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR Charles R. Law 802 Madison Ave.		ADDRESS		25a REC'D BY REGISTRAR DATE AUG 24 1967		25b. REGISTRAR'S SIGNATURE James Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10466

10466

1 PLACE OF DEATH a. COUNTY <u>ALBANY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>ALBANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Steuersville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Steuersville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Northwestern Hospital</u>		d. STREET ADDRESS <u>R.F.D. #1 Box 350</u>	
3. NAME OF DECEASED (Type or print) <u>William L. January</u>		4. DATE OF DEATH <u>Jan 30 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/7/1924</u>
9. AGE (In years, last birthday) <u>42</u> Y's		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>30</u> Hours <u>7</u> Min <u>19</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph January</u>		14. MOTHER'S MAIDEN NAME <u>Lurine Degraff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>717-074621</u>	
17. INFORMANT <u>Josephine A. January</u>		Address <u>Steuersville</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Calculus in prostate</u> DUE TO <u>Enlarged Heart</u> CONDITIONS (if any, which gave rise to immediate cause (a) stating the underlying cause lost) <u>Arteriosclerosis of the Heart</u> DUE TO <u>Arteriosclerosis of the Heart</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Albert L. Anderson</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>ALBERT L. ANDERSON</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town or county) <u>Steuersville, Md.</u>	
22. DATE SIGNED <u>Jan 30 1967</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/2/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Our Lady of the Field</u>		23d. LOCATION (City or town) (County) (State) <u>Steuersville, Md.</u>	
24. FUNERAL DIRECTOR <u>Robert P. Ware</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Singleton Funeral Home, Glen Burnie</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>SEP 5 1967</u>			

CERTIFICATE OF DEATH

10469

10467

1 PLACE OF DEATH a COUNTY <u>Ch. Co.</u> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charmersville</u> c LENGTH OF STAY IN 16 <u>Charmersville</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Ch. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charmersville</u> d. STREET ADDRESS <u>Route 5 1314 32</u>	
3 NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>C</u> Last <u>JOHNSON</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country) <u>MD.</u>
13. FATHER'S NAME <u>Charles Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Emma Little</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-44-7550</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>351X</u> DUE TO (b) <u>Massive embolic vascular hemorrhage</u> DUE TO (c) <u>8 hrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 8)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/18</u> , 19 <u>67</u> , to <u>8/19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/19</u> , 19 <u>67</u> , and that death occurred at <u>8/19</u> , 19 <u>67</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John W. Schum</u>		22b. ADDRESS	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
<u>Burial</u>	<u>8-23-67</u>	<u>Baltimore</u>	<u>Baltimore</u>
24. FUNERAL DIRECTOR <u>William Reese</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>AUG 21 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

10468

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10468

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Q. C. Co</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o STATE <u>MD</u> b COUNTY <u>Q. C. Co</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Glen Burnie</u>		c LENGTH OF STAY N Id <u>-</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>North Arundel Hospital</u>		d STREET ADDRESS <u>Box 322, Rt. #1</u>	
3 NAME OF DECEASED (Type or print) <u>Jones</u>		DATE OF DEATH Month <u>8</u> Day <u>26</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Caucasian</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>?</u>
9 AGE (n years last birthday) <u>80</u> yrs		10a USUA. OCCUPATION (Give kind of work done during most of working life, even retired) <u>Retired</u>	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Durham N Carolina</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>Unknown</u>	
14 MOTHER'S MAIDEN NAME <u>Unknown</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO <u>219-05-9220</u>		17 INFORMANT <u>Mrs Polly Jones, same</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral accident (stroke)</u> DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Albert H. Anderson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>ALBERT H. ANDERSON</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>for E. Linder</u>	
		Address (Street, city, town, or county) <u>44 S. ...</u>	
22a B. RIAL CREMATION REMOVAL (Specify)	22b DATE THEREOF <u>8/31/67</u>	22c NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cemetery</u>	22d LOCATION (City or town) (County) (State) <u>A A County Md</u>
24 FUNERAL DIRECTOR <u>Adolphus Halstead</u>		25a REC'D BY REGISTRAR <u>AUG 30 1967</u>	
ADDRESS <u>1206 W North Ave</u>		25b STRAIGHT SIGNATURE <u>J. ...</u>	

CERTIFICATE OF DEATH

10471

10459

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA 21122</u>	
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <u>N. ARUNDEL CONV. CENTER</u>		d. STREET ADDRESS <u>Box 255, Park Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM KAUFFMAN</u>		4. DATE OF DEATH Month Day Year <u>8 14 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1894</u> <u>1-18-1884</u>
9. AGE (In years lost birthday) <u>73</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired Police (Balto City Police Dept.)</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Herman Kauffman</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Foster</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>217-26-4178</u>	
17. INFORMANT <u>N. ARUNDEL CONV. CENT.</u>		Address <u>313 Hosp. Dr. GLEN BURNIE, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ca of pancreas.</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>67</u> , to <u>Aug 14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug 7</u> , 19 <u>67</u> , and that death occurred at <u>1:15 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>C. Earl Hill</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>8-14-67</u>
22c. PHYSICIAN'S NAME (Type) <u>Dr. C. Earl Hill</u>		22d. ADDRESS <u>Glenburnie, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>8/17/67.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. City</u>		25a. REC'D BY REGISTRAR <u>Aug 15 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10472

CERTIFICATE OF DEATH

10470

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to containers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>2 years 7 mon.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>29</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>1011 Cooks Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Caroline Miller Kennedy</u>		4. DATE OF DEATH Month <u>8</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-4-32</u>
9. AGE (In years, months, days) <u>34</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>67</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown companion</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>employee</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Germany</u>		12. CITIZENSHIP OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. Miller</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>unknown</u>	
17. INFORMANT <u>Hospital Records, Crownsville, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <u>4201</u> IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease with old myocardial infarct.</u> DUE TO (b) <u>ial infarct.</u> DUE TO (c) <u>lost</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mild Hypertension, Generalized arteriosclerosis, Chronic Brain Syndrome</u>			
19. WAS AUTOPSY PERFORMED? <u>NO</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>10/1</u> , 19 <u>64</u> , to <u>8/7</u> , 19 <u>67</u> , that (2) (we) last saw the deceased alive on <u>8/7</u> , 19 <u>67</u> , and that death occurred at <u>6:35</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>L. Benedict, M.D.</u>		22b. DATE SIGNED <u>8/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>8/9/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Ceme</u>	23d. LOCATION (City or town) (County) (State) <u>Old Baltimore AT Md</u>
24. FUNERAL DIRECTOR <u>Robert S. Baranov</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 10 1967</u>	

10473

CERTIFICATE OF DEATH

10471

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Res dence before admision) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel		d. STREET ADDRESS 524 Pt. Pleasant Road	
3. NAME OF DECEASED (Type or print) Melvin L. Knight		4. DATE OF DEATH Month August Day 25 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH 9-21-02
9. AGE (in years) 64 yrs		10. IF UNDER 1 YEAR Months 19 Days 67 Hours 19 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY A.A. Co. Public Works	
11. BIRTHPLACE (County & State, or foreign country) A.A. Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Lee Knight		14. MOTHER'S MAIDEN NAME Addie Rebecca Hood	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 212-09-1379	
17. INFORMANT Mrs. Grace Turner - Odenton, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock, unknown etiology DUE TO (b) post hemorrhagic peritonitis DUE TO (c) post Gram negative Sepsis	
19. INTERVAL BETWEEN ONSET AND DEATH 12 hrs		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) pos. Gall bladder disease	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/23, 1967 to 8/25, 1967 that (I) (we) last saw the deceased alive on 8/25, 1967 , and that death occurred at 12:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Paul J. Chancy MD		22b. DATE SIGNED 8/25/67	
22c. PHYSICIAN'S NAME (Type) Paul J. Chancy MD		22d. ADDRESS 801 Chain Key SE, Glen Burnie	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 29, 1967	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Glen Burnie A.A. Md.	
24. FUNERAL DIRECTOR Devlin E. Hopping		25a. REC'D BY REGISTRAR AUG 29 1967	
25b. REGISTRAR'S SIGNATURE John Charles Judge		25c. HOPPING FUNERAL HOME * Annapolis, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10474

CERTIFICATE OF DEATH

10472

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-GLEN BURNIE		c. LENGTH OF STAY IN IB 9 HOURS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL HOSPITAL		d. STREET ADDRESS 5511 PIONEER DRIVE	
3. NAME OF DECEASED (Type or print) First JOHN Middle Bernard Last KUTCHEY		4. DATE OF DEATH Month AUGUST Day 7 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/11/06
9 AGE (in years last birthday) 61 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO SALESMAN	10b. KIND OF BUSINESS OR INDUSTRY AUTO SALES
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Kutchey		14. MOTHER'S MAIDEN NAME Eva ?unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-28-9012	
17. INFORMANT Mrs. Helen Kutchey		Address 5511 Pioneer Dr. #21214	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO hypertensive vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration pneumonia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug. 6, 1967 , to Aug. 7, 1967 , that (I) (we) last saw the deceased alive on Aug. 7, 1967 , and that death occurred at 7:30 AM , from causes and on the date stated above.			
22a. SIGNATURE B. G. de Gunzman		22b. DATE SIGNED Aug. 7, 1967	
22c. PHYSICIAN'S NAME (Type) B. A. de GUNZMAN		22d. ADDRESS NORTH ARUNDEL HOSP.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 10, 1967	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR George A. Weber		ADDRESS 705 South Ann Street 21231	
25a. REC'D BY REGISTRAR DATE AUG 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

10475

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10473

1 PLACE OF DEATH a. COUNTY <i>A.A. Co.</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Washington D.C.</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY in 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>D.O.A. - Anne Arundel General H.</i>		d. STREET ADDRESS <i>1215 Kearny St. N.E.</i>	
3 NAME OF DECEASED (Type or print) First <i>Fabian</i> Middle <i>A</i> Last <i>LABAT</i>		4 DATE OF DEATH Month <i>8</i> Day <i>10</i> Year <i>1967</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/23-92</i>
9. AGE (in years last birthday) <i>74</i> yrs		10. IF UNDER 1 YEAR Months <i>10</i> Days <i>19</i> Hours <i>07</i> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. FED. GOV'T.</i>	
11. BIRTHPLACE (State or foreign country) <i>MISSISSIPPI</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>JOSEPH LABAT</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN -</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO <i>NOT STATED</i>	
17. INFORMANT <i>MRS. ESTELLA LABAT - WIFE - SAME</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>751X DUE TO Drawing</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>✓</i> (b) <i>✓</i> (c) <i>✓</i>		INTERVA. BETWEEN ONSET AND DEATH <i>✓</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Boating Accident</i>	
20c. TIME OF INJURY Hour <i>am</i> Month, Day, Year <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <i>ANNE ARUNDEL MD</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E. Linhardt</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <i>3015-12th Ave</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>8/14/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Ignace</i>	23d. LOCATION (City or Town) (County) (State) <i>Suitland Md</i>
24. FUNERAL DIRECTOR <i>17000 Federal Home</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
ADDRESS		DATE <i>AUG 22 1967</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1 67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>A.A. Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>WASH. D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.H. Anne Arundel Gen.</u>		d. STREET ADDRESS <u>1215 Kearney St.</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph. L. Labat</u>		4. DATE OF DEATH Month <u>8</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/25/24</u>
9. AGE (In years, last birthday) <u>43</u> yrs		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>19</u> Hours <u>67</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PUBLIC SCHOOLS</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FABIAN A. LABAT</u>		14. MOTHER'S MAIDEN NAME <u>E. STELLA NICKENS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NOT STATED</u>	
17. INFORMANT <u>MRS. MARGARET G. LABAT - WIFE - SAME</u>		Address	
18. CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Boating Accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>pm</u> <u>8/9</u> 19 <u>67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) <u>Chesapeake Bay</u>
20f. (City or town) <u>MD</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>8/12/67</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town or county)			
23a. BURIAL (CREMATION, REMOVAL) (Specify) <u>8/14/67</u>	23b. DATE TIME OF	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	23d. LOCATION (City or town) (County) (State) <u>Greenwood Md</u>
24. FUNERAL DIRECTOR <u>K. Lewis Funeral Home</u>		ADDRESS <u>2015-12th St</u>	
25a. REC'D BY REGISTRAR <u>AUG 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10477

CERTIFICATE OF DEATH

10475

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admittance) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital Annapolis, Md				e. STREET ADDRESS A 107 Smithwood Avenue			
3. NAME OF DECEASED (Type or print) Marguerite E. Lidard				4. DATE OF DEATH Month August Day 25 Year 1967			
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 April 1891		9. AGE (In years last birthday) yrs. 76	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) Md.	
13. FATHER'S NAME Albert McCullough				14. MOTHER'S MAIDEN NAME MARY McCaffrey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO		17. INFORMANT Address John E. Lidard 107 Smithwood Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of the lower colon							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 25 August 1967 , and that death occurred on 25 August 1967 , from causes on and on the date stated above.							
22a. SIGNATURE James J. Quinn				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 25 August 1967	
22c. PHYSICIAN'S NAME (Type) JAMES J. QUINN, LCDR MC USN				22d. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD.			
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		23b. DATE THEREOF 8/28/67		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City or Town) (County) (State) BA/To. Md.	
24. FUNERAL DIRECTOR ADDRESS McNabb Funeral Home, Baltimore, Md.				25a. REC'D BY REGISTRAR AUG 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

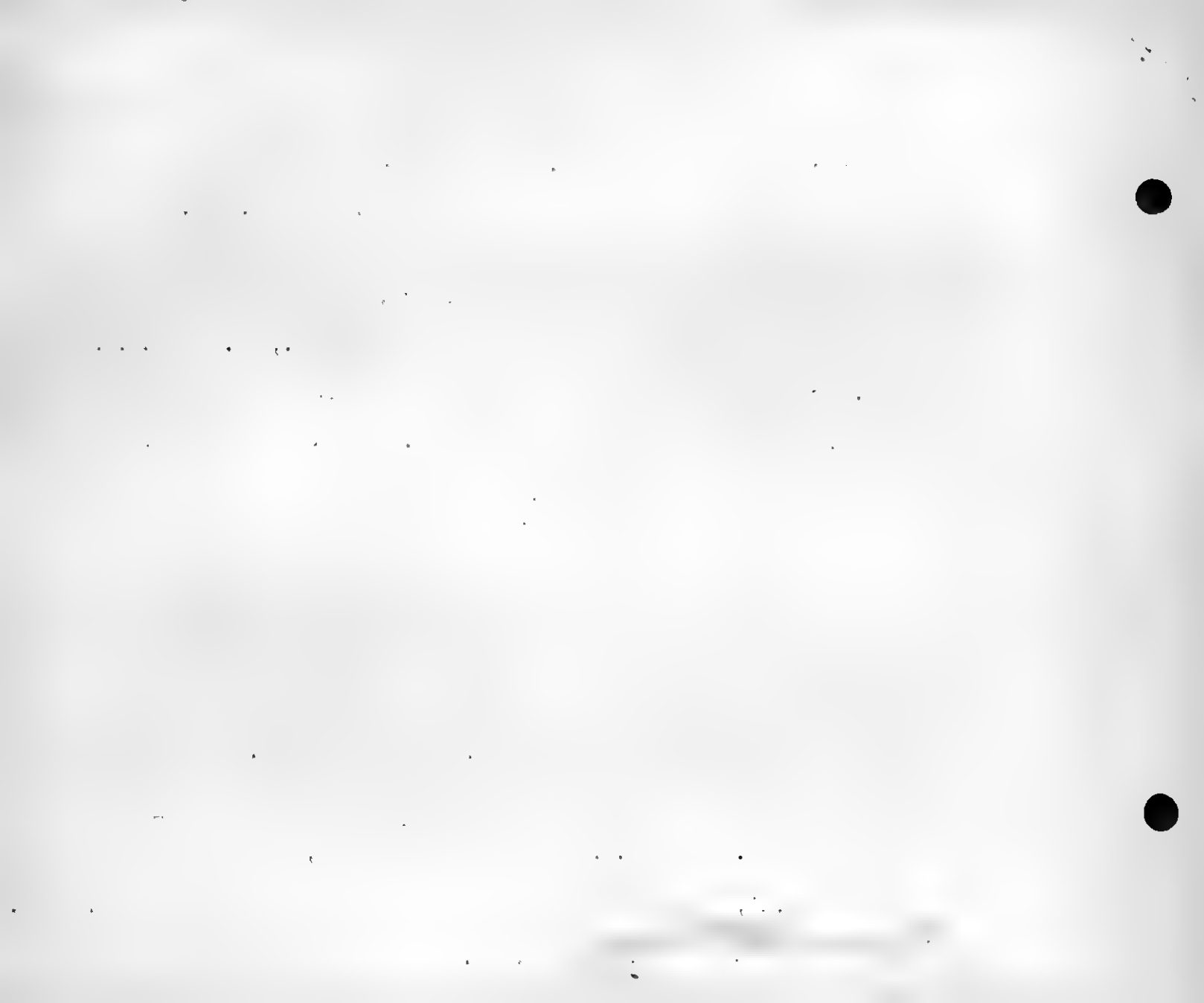
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10476

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Md.		c. LENGTH OF STAY IN 1b 25 hrs. - 52m	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel,	
f. STREET ADDRESS 12923 Laurel-Bowie Rd. Apt. 204		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles First Middle Last Lindenmuth		4. DATE OF DEATH August 20 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 19, 1967
9. AGE (In years last birthday) yrs. 1		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 52	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles D. Lindenmuth		14. MOTHER'S MAIDEN NAME Bessie Ann Maxim	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. none	
17. INFORMANT Bessie A. Lindenmuth-		Address 12923 Laurel-Bowie	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> Conditions, if any, which gave rise to immediate cause (b) <i>Pneumonia</i> underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug. 19, 1967, to Aug. 20, 1967, that (I) (we) last saw the deceased alive on August 20, 1967, and that death occurred at 8-35 PM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Alvin W. Hecker</i>		22b. DATE SIGNED 8-20-67	
22c. PHYSICIAN'S NAME (Type) Alvin W. Hecker M.D.		22d. ADDRESS Glen Burnie, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 25, 1967	23c. NAME OF CEMETERY OR CREMATORY Wareham Town Cemetery	23d. LOCATION (City, town or county) (State) Wareham, Plymouth Co. Mass.
24. FUNERAL DIRECTOR <i>Engene B. Blum</i>		25a. REC'D BY REGISTRAR AUG 23 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>10479</p> </div> </div>									
<p>1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND</p>					<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel</p>				
<p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brooklyn Park</p>			<p>c. LENGTH OF STAY IN 1D</p>		<p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brooklyn Park</p>				
<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4012 Ritchie Highway</p>					<p>d. STREET ADDRESS 4012 Ritchie Highway 21225</p>				
<p>3. NAME OF DECEASED (Type or print) First Edgar Middle Rowen Last Lucke Sr.</p>					<p>4. DATE OF DEATH Month Aug Day 22, Year 1967</p>				
<p>5. SEX Male</p>		<p>6. COLOR OR RACE White</p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH Jan. 14, 1895</p>		<p>9. AGE (In years last birthday) 72 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired</p>				<p>10b. KIND OF BUSINESS OR INDUSTRY Tavern Owner</p>		<p>11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? U. S. A.</p>	
<p>13. FATHER'S NAME Joseph Lucke</p>					<p>14. MOTHER'S MAIDEN NAME Mary Ellen Cooney</p>				
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW1</p>				<p>16. SOCIAL SECURITY NO. WW1</p>		<p>17. INFORMANT Address Mr. Edgar R. Lucke, Jr. 4012 Ritchie Hwy 21225</p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma @ Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) w Metastases DUE TO (c)</p>								<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>									
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>					
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19</p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from November, 1963, to August, 1967, that (I) (we) last saw the deceased alive on 8/22 1967, and that death occurred at 11:40 AM, from the causes and on the date stated above.</p>									
<p>22a. SIGNATURE Mario J. Reda MD</p>						<p>22b. DATE SIGNED 8/24/67</p>			
<p>22c. PHYSICIAN'S NAME (Type) MARIO J. REDA MD.</p>						<p>22d. ADDRESS 4016 RITCHIE HWY.</p>			
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>23b. DATE THEREOF 8/26/67</p>		<p>23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park</p>		<p>23d. LOCATION (City, town or county) (State) Anne Arundel Co. Md.</p>			
<p>24. FUNERAL DIRECTOR McCully Funeral Home</p>				<p>ADDRESS 237 Patapsco Ave.</p>		<p>25a. REC'D BY REGISTRAR AUG 25 1967</p>		<p>25b. REGISTRAR'S SIGNATURE Charles J. ...</p>	



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MAYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MAYLAND 21201											
10480 CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN lb 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital						d. STREET ADDRESS 6 Housley Road				e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Anna Marie LYNN			First Middle Last			4. DATE OF DEATH August 3 1967			Month Day Year		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 5, 1882		9. AGE (in years last birthday) 85 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES LADY				10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (County & State, or foreign country) Balto. Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME STEPHEN HEIM						14. MOTHER'S MAIDEN NAME UNK					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO 215 261850		17. INFORMANT ARTHUR J. LYNN #2			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331x Cardiovascular accident. DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Lobes pneumonia										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) physician attended the deceased from March 1967 to Aug. 3, 1967 , that (I) did not last saw the deceased alive on Aug. 3, 1967 , and that death occurred at _____ M, from causes and on the date stated above.											
22a. SIGNATURE John L. Hedeman				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED 8/3/67			
22c. PHYSICIAN'S NAME (Type) John L. Hedeman, M.D.				22d. ADDRESS 1407 Forest Drive, Annapolis, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8-5-67		23c. NAME OF CEMETERY OR CREMATORY LONDON PARK				23d. LOCATION (City or Town) (County) (State) BALTIMORE MD.			
24. FUNERAL DIRECTOR John M. Loggins Annapolis, Md.						25a. REC'D BY REGISTRAR DATE AUG 7 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

10481

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>A. A.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>Annapolis</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A. A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>161 Obery Court</u>		d. STREET ADDRESS <u>161 Obery Ct.</u>	
3. NAME OF DECEASED (Type or print) <u>Georganna Mack</u> First Middle Last		4. DATE OF DEATH Month <u>8</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-5-1888</u> 9. AGE (In years last birthday) <u>79</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if essential, in red) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (Country & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Snowden</u>		14. MOTHER'S MAIDEN NAME <u>Emma Parker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Ruth Johnson Davidsonville</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>metastatic CA</u> 1530 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Adeno carcinoma - previously Col.</u> DUE TO (c) <u>about</u>		INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>4 mos</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>A.C.U.D.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/26</u> , 1967, to <u>8/26</u> , 1967, that (I) (we) last saw the deceased alive on <u>8/26</u> , 1967, and that death occurred at <u>6 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Faye W. Allen</u> M.D.		22b. DATE SIGNED <u>8/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Faye W. Allen</u>		22d. ADDRESS <u>62 Cathedral St Annap</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-30-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pine Lawn</u>	23d. LOCATION (City or Town) (County) (State) <u>Annapolis MD</u>
24. FUNERAL DIRECTOR <u>William Reese # Anna. MD</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>AUG 29 1967</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10482

10480

1 PLACE OF DEATH a COUNTY <u>AA.CO.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <u>MD</u> b COUNTY <u>AA.CO.</u>	
b CITY OR TOWN (If outside of corporate limits write RURAL and give nearest town) <u>ANNAPOLIS</u>		c LENGTH OF STAY N 1b <u>Edge. water</u>	
a NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - Anne Arundel General</u>		d STREET ADDRESS <u>Rt. 1 - Box 387</u>	
3 NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>F</u> Last <u>MARTIN</u>		4 DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>67</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-7-65</u>
9 AGE (In years last birthday) yrs <u>2</u>		10 IF UNDER 1 YEAR Months <u>1</u> Days <u>11</u> Hours <u>11</u> Min <u>11</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>JAMES B. MARTIN</u>		14 MOTHER'S MAIDEN NAME <u>ELEANOR BEIKLY</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>-</u>	
17 INFORMANT <u>JAMES R. MARTIN #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO <u>7218</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Heart</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PR MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fallen in water off beach</u>	
20c TIME OF INJURY Month Day, Year Hour a.m. <u>8:15</u> p.m. <u>1967</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <u>Swimming</u>	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Swimming</u>		20f (City or town) (County) (State) <u>AA CO MD</u>	
21. I certify that I took charge of the remains described above. I performed an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. White</u>		22. DATE SIGNED <u>8-18-67</u>	
EXAMINER'S NAME (Type) <u>E. L. White</u>		Address (Street city, town, or county)	
23a BURIAL CREMATION, REMOVAL Specimen	23b DATE THEREOF <u>8-22-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d LOCATION (City or town) (County) (State) <u>Mt. Pleasant N.Y.</u>
24 FUNERAL DIRECTOR <u>John M. Long</u>		25a REC'D BY REGISTRAR <u>AUG 22 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10483

10483

1. PLACE OF DEATH a. COUNTY <u>AA</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u> c. LENGTH OF STAY IN 1b <u>33</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1109 Nursery Rd -</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u> d. STREET ADDRESS <u># 1109 W. Nursery Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Attilio Angelo Mazzatorta</u> First Middle Last 4. DATE OF DEATH <u>Aug. 16 1967</u> Month Day Year				5. SEX <u>M</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan 2 - 1893</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. AGE (In years last birthday) <u>69</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cash Operator</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>A.A. Corporation</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Vincenzo</u> 14. MOTHER'S MAIDEN NAME <u>Lucretia (Unknown)</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>12-12-03-8211</u> 17. INFORMANT <u>Myrtle Mazzatorta</u> Address <u>(as above)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-vascular Disease</u> DUE TO <u>Hypertension & Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u></u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hr</u> <u>5 hr</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u></u>				20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. <u></u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> 20f. (City or town) (County) (State) <u></u>			
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> to <u>3/16</u> , 1967 , that (I) (we) last saw the deceased alive on <u>8/16</u> , 1967 , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles L. Ball Jr.</u> 22c. PHYSICIAN'S NAME (Type) <u>Charles L. Ball Jr.</u>				22b. DATE SIGNED <u></u> 22d. ADDRESS <u>Linthicum Md</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Aug. 19, 1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Park</u> 23d. LOCATION (City, town or county) (State) <u>Elkridge R.F.D. Maryland</u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>Engene B. Blum</u> ADDRESS <u>Singleton Funeral Home, Glen Burnie, Md.</u> 25a. REC'D BY REGISTRAR <u>Charles Joyce</u> 25b. REGISTRAR'S SIGNATURE <u></u> DATE <u>AUG 18 1967</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10484		10482	
1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Res. den. before adm. ssion) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL HOSPITAL		d. STREET ADDRESS 54 Southgate Ave	
3 NAME OF DECEASED (Type or print) First KATHERINE Middle H. Last MCCUTCHAN		4. DATE OF DEATH Month AUGUST Day 1 Year 1967	
5 SEX Female	6. COLOR OR RACE Cauc.	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 December 1911
9 AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) COURT STENOGRAPHER		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) ANNAPOLIS MD		12 CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME JAMES HOLLAND		14. MOTHER'S MAIDEN NAME SELINA CURRY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. -	
17 INFORMANT Address MICHAEL V. MCCUTCHAN #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) SEPTICEMIA 345X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) PNEUMONIA URINARY TRACT INFECTION (c) SECONDARY TO MULTIPLE SCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) just saw the deceased alive on 1 August 1967, and that death occurred at 10:15M, from causes and on the date stated above.			
22 SIGNATURE J. J. QUINN, LCDR MC USN		22b DATE SIGNED 2 Aug 67	
22c PHYSICIAN'S NAME (Type) J. J. QUINN, LCDR MC USN		22d ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD.	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF AUG 4 1967	23c NAME OF CEMETERY OR CREMATORY ST ANNE'S CEM.	23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD
24 FUNERAL DIRECTOR JOHN TAYLOR AND SONS, DUKE OF GLOUCESTER ST. ANNAPOLIS, MD.		25a. REC'D BY REGISTRAR DATE AUG 4 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10485

10483

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b Pasadena	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS 209th St. & Outing Road	
3. NAME OF DECEASED (Type or print) Charles F. McGuirk		4 DATE OF DEATH Month August Day 28 Year 1967	
5. SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-30-1914
9 AGE (In years last birthday) 53 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver		10b. KIND OF BUSINESS OR INDUSTRY Diamond Cab Co.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bernard P. McGuirk		14. MOTHER'S MAIDEN NAME Martha A. Totzauer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) W W II		16 SOCIAL SECURITY NO. 215-10-5675	
17 INFORMANT Mrs. Grace E. McGuirk		Address 209th St. & Outing Rd.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) acute coronary thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-18-49 , 19__, to 7-28-67 , 19__, that (I) (we) last saw the deceased alive on 7-28-67 , 19__, and that death occurred at __ M, from causes and on the date stated above.			
22a. SIGNATURE Dr. Harry S. Gimble		22b. DATE SIGNED 7-29-67	
22c. PHYSICIAN'S NAME (Type) Dr. Harry S. Gimble		22d. ADDRESS 4605 Edmondson Avenue	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-1-1967	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR AUG 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



1
copy - 11a

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11895

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if not at residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN lb <u>8 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>1025 Mounument Street</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>William McMullen</u>				4 DATE OF DEATH Month <u>8</u> Day <u>25</u> Year <u>19 67</u>					
5 SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/19/32</u>			
9 AGE (in years last birthday) <u>35</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>			
13. FATHER'S NAME <u>Charlie McMullen</u>				14. MOTHER'S MAIDEN NAME <u>Cousai</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Hospital Records, Crownsville, Maryland</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant Hypertension</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>445x</u> DUE TO (c) <u>-----</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of liver; alcoholism</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> min <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8/17/</u> , 19 <u>67</u> , to <u>8/25/</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/25</u> , 19 <u>67</u> , and that death occurred at <u>8:40 M.</u> from causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>8/25/67</u>		22c. PHYSICIAN'S NAME (Type) <u>William Zeese, II - Wm. Zeese, M.D.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				23b. DATE THEREOF <u>9/12/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>21. of Md.</u>			
24. FUNERAL DIRECTOR <u>William Zeese, II - Wm. Zeese, M.D.</u>				25a. REC'D BY REGISTRAR <u>SEP 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10486

10484

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY <u>P. N. Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General</u>		e. STREET ADDRESS <u>215 Linney Ave</u>	
3. NAME OF DECEASED (Type or print) <u>William W. McNamara</u>		4. DATE OF DEATH Month <u>8</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9-21</u>
9. AGE (In years last birthday) yrs <u>45</u>		10. IF UNDER 1 YEAR Months <u>27</u> Days <u>19</u> Hours <u>07</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ADM PUBLIC WORKS CLERK USNA</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CAMBRIDGE MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>CAMBRIDGE MD.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>WALTER W. McNAMARA</u>		14. MOTHER'S MAIDEN NAME <u>MYRTLE E. JACKSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give year of discharge) <u>YES</u>		16. SOCIAL SECURITY NO <u>WW 0</u>	
17. INFORMANT <u>JEANNETTE A. McNAMARA #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Dysphagia C.V.S.</u> <u>443X</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Section</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Hubert</u> M.D.		22. DATE SIGNED <u>8/27/67</u>	
EXAMINER'S NAME (Type) <u>E. L. Hubert</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, or other disposal <u>BURIAL</u>	23b. DATE THEREOF <u>Aug 25, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST ANNE'S CEM.</u>	23d. LOCATION (City or town) (County) (State) <u>ANNAPOLIS MD.</u>
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR-SONS</u> ADDRESS <u>ANNAPOLIS MD</u>		25a. REC'D BY REG. STRAP DATE <u>AUG 28 1967</u>	
		25b. REG. STRAP'S SIGNATURE <u>James Judge</u>	

10584

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the tag papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>2021 Wells Manor Ave. #7</u>	
3. NAME OF DECEASED (Type or print) First <u>Marcia</u> Middle <u>Cecile</u> Last <u>Merkle</u>		4. DATE OF DEATH Month <u>August</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28, 1926</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Lillian Rubenstein</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>216-20-9010</u>		17. INFORMANT <u>Mr. Charles T. Merkle, Jr.</u> Address <u>2021 Wells Manor Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO (b) <u>Wolff-Parkinson-White Syndrome</u> DUE TO (c) <u>15 Yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the deceased) attended the deceased from <u>June</u> , 19 <u>64</u> , to <u>Aug.</u> , 19 <u>67</u> , that (I) (the deceased) last saw the deceased alive on <u>8th June</u> , 19 <u>67</u> , and that death occurred at <u>5:40 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Bernard Tabatzuik</u>		22b. DATE SIGNED <u>8/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bernard Tabatzuik</u>		22d. ADDRESS <u>2701 Whitney Avenue, Balto., Md. #15</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/29/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Hebrew</u>		23d. LOCATION (City or Town) (County) (State) <u>Reisterstown, Maryland</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u>		25a. REC'D BY REGISTRAR <u>SEP 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

CERTIFICATE OF DEATH

10486

10486

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 8 hours			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				e. STREET ADDRESS 21 Riverside Drive			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle (none) Last MERRIFIELD				4. DATE OF DEATH Month August Day 10 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 28, 1888	9. AGE (n years last birthday) yrs 79	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME ALPHONSUS GERMAK				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO NONE				16. SOCIAL SECURITY NO 578-05-5234B		17. INFORMANT HOMER MERRIFIELD Address 21 Riverside Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE CEREBRAL HEMORRHAGE DUE TO (b) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE 72 YRS. DUE TO (c) GENERALIZED ARTERIOSCLEROSIS 72 YRS.						INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 1965 , 19 to Aug. 10 , 19 67 , that (I) (we) last saw the deceased alive on Aug. 10 , 19 67 , and that death occurred at 7:30 PM M, from causes and on the date stated above.							
22a. SIGNATURE Arthur Lankford Jr. M.D.				22b. DATE SIGNED 8-11-67		22c. PHYSICIAN'S NAME (Type) Arthur Lankford, Jr. M.D.	
22d. ADDRESS 2934 Mountain Road, Pasadena, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8-14-67	23c. NAME OF CEMETERY OR CREMATORY LONDON PARK	23d. LOCATION (City or town) (County) (State) BALTIMORE MD				
24. FUNERAL DIRECTOR Geo L. Schwab Funeral Home Francis W. Miller 2101 Redbank Ave.				25a. REC'D BY REGISTRAR DATE AUG 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

I

REMOVAL-Burial

Items 18-21 Film 392
9-14-67 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10489

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10487

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE c. LENGTH OF STAY IN 1b North Arundel Hospital d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE New Jersey b. COUNTY Secaucus c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) 756 Golden Avenue d. STREET ADDRESS 756 Golden Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) EDWARD First Middle Last MESAGAES		4 DATE OF DEATH Month Day Year August 29, 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 16, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Service Trucking Co- New Jersey	
11 BIRTHPLACE (State or foreign country) U.S.A.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME John Mesagaes		14 MOTHER'S MAIDEN NAME May Lavelle	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 141 10 4981	
17 INFORMANT Mack Funeral Home		Address Secaucus, N.J.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive and arteriosclerotic cardiovascular disease 440X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple traumatic injuries		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. Driver of truck which ran off road		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Driver of truck which ran off road	
20c. TIME OF INJURY Month, Day, Year 6:30 a.m. 8-29 1967		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) -- Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.		22. DATE SIGNED August 29, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL-Burial		23b. DATE THEREOF 9-2-67	
23c. NAME OF CEMETERY OR CREMATORY Hillside Cemetery		23d. LOCATION (City or town) (County) (State) Lynchhurst N.J.	
24 FUNERAL DIRECTOR Mack Memorial Home		25a. REC'D BY REGISTRAR SEP 1 1967	
ADDRESS Secaucus, New Jersey		25b. REGISTRAR'S SIGNATURE Charles Judge	

CERTIFICATE OF DEATH

104-0

10488

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY in 1b <u>1 year 5 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>20 Indian Head Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Ashby Walter Millar</u>				4 DATE OF DEATH Month <u>8</u> Day <u>13</u> Year <u>1967</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 a. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept. 12, 1887</u>		9. AGE (in years as of birthday) <u>79</u> yrs	IF UNDER 1 YEAR Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of life, or to even if retired) <u>U.S. Govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ret. U.S. Govt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Charles, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Millar</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Carpenter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. <u>215-46-2870</u>		17. INFORMANT <u>Hospital Records, Crownsville, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>DEHYDRATION</u> (c) <u>ARTERIOSCLEROSIS GENERALIZED</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dehydration; Arteriosclerosis generalized; Possible Active T.B.</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>7:55</u>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that (it) (this hospital) attended the deceased from <u>3/13</u> , 19 <u>66</u> , to <u>8/13</u> , 19 <u>67</u> , that (it) (we) last saw the deceased alive on <u>8/13</u> , 19 <u>67</u> , and that death occurred at <u>7:55 M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>L. Benedict, M.D.</u>				22b. DATE SIGNED <u>8/14/67</u>		22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>	
23a. BURIAL, CREMATION, or REMOVAL (Specify)		23b. DATE THEREOF <u>8-16-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OLD DURHAM</u>		23d. LOCATION (City or Town) (County) (State) <u>IRONSIDES MD.</u>	
24. FUNERAL DIRECTOR <u>HUNT FUNERAL HOME, WALDORF, MD.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
10489											
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>AA</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RT 5 Box 18 Old Annapolis Rd</u>						d. STREET ADDRESS <u>OLD ANNAPOLIS RD</u>					
3. NAME OF DECEASED (Type or print) First <u>RALPH</u> Middle <u>NUNLEY</u> Last <u>NUNLEY</u>						4. DATE OF DEATH Month <u>Aug</u> Day <u>16</u> Year <u>1967</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 19, 1895</u>		9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BURNER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SCRAP MILL</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Boyd Co., Ky</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>		
13. FATHER'S NAME <u>ROBERT F. NUNLEY</u>						14. MOTHER'S MAIDEN NAME <u>MARTHA CLAY</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>178-05-4358</u>		17. INFORMANT <u>Mrs F O A NUNLEY</u> Address <u>SAME</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> DUE TO <u>Cerebral thrombosis with right</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>hemiplegia</u> DUE TO <u>hemiplegia</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Delayed inguinal hernia - Not symptomatic</u>											
INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u> <u>15 years</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 15, 1964</u> to <u>August 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>August 15, 1967</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>R.M. McLaughlin</u>						22b. DATE SIGNED <u>8/16/67</u>			22c. PHYSICIAN'S NAME (Type) <u>R.M. McLAUGHLIN</u>		
22d. ADDRESS <u>3108 M. Mulan Rd. Pasadena, Md</u>						22e. REC'D BY REGISTRAR <u>21777</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>Aug. 18, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NAT. CEM.</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE MD</u>			
24. FUNERAL DIRECTOR <u>George J. Gonce-4001 Ritchie Hwy., Baltimore</u>						25a. REC'D BY REGISTRAR <u>Aug 18 1967</u>					
25b. REGISTRAR'S SIGNATURE <u>g. Charles</u>											

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10492

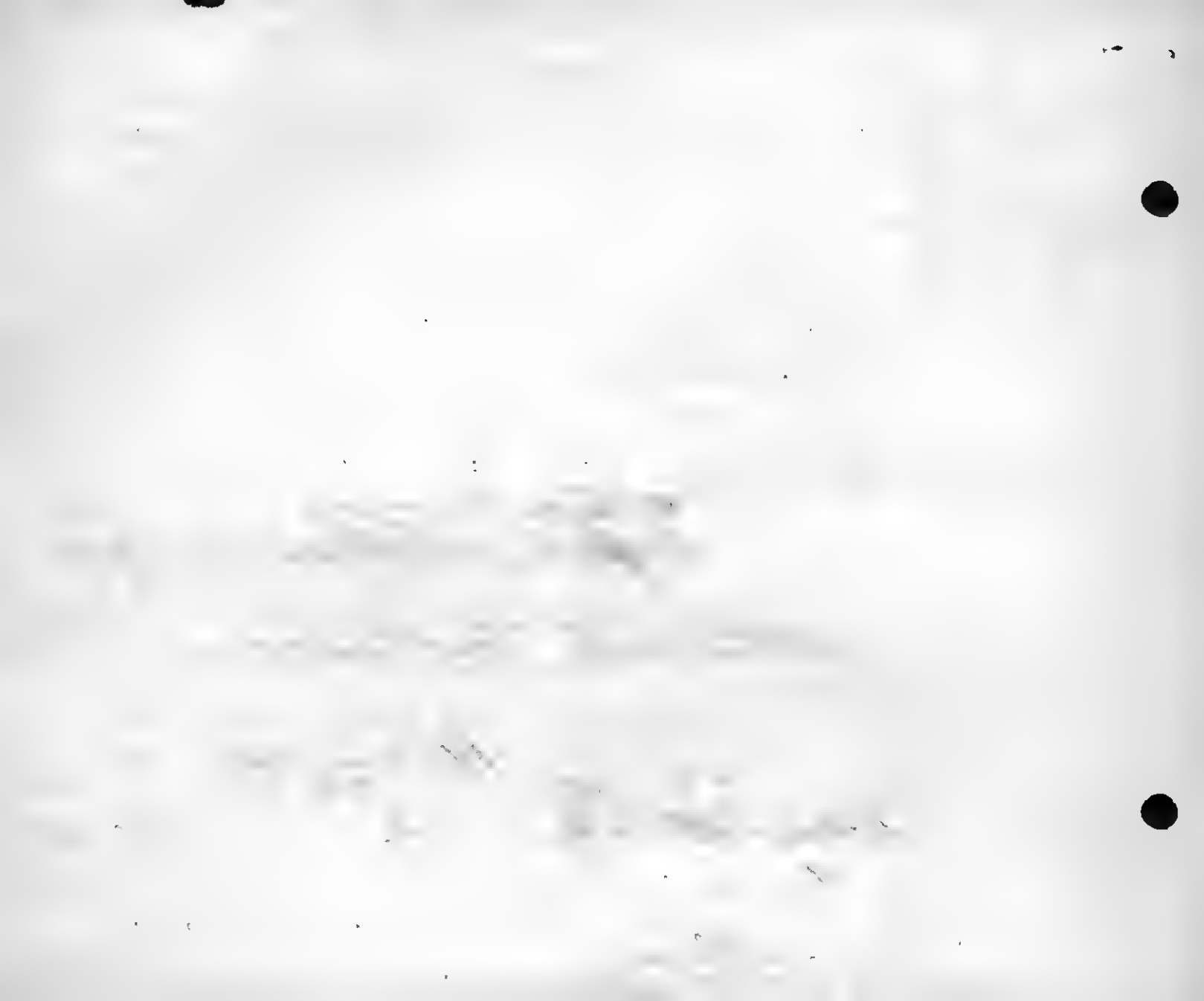
CERTIFICATE OF DEATH

10480

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN To 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		e. STREET ADDRESS 319 Orchard Road	
3. NAME OF DECEASED (Type or print) May C		4. DATE OF DEATH 8 9 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-30-87
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) West Virginia
13. FATHER'S NAME Ell Helton		14. MOTHER'S MAIDEN NAME Mollie Britt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO 235-09-7611-0	
17. INFORMANT Mr. George L. Ord (Son) Same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 2, 2, 3 IMMEDIATE CAUSE (a) Bilateral Pneumonia DUE TO (b) Myeloid Metaplasia DUE TO (c) 4 yrs		INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1962 to 4/9 , 1967, that (I) (we) last saw the deceased alive on 8-9-1967 , and that death occurred at 7:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Hilary T. O'Hearlly		22b. DATE SIGNED 8-10-67	
22c. PHYSICIAN'S NAME (Type) Hilary T. O'Hearlly, M.D.		22d. ADDRESS 301 Central Avenue, Glen Burnie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 12, 1967	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR Singleton Funeral Home		25a. REC'D BY REGISTRAR DATE AUG 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



10493

CERTIFICATE OF DEATH

10491

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c LENGTH OF STAY IN 1b <u>Annopolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>135 Spa View Avenue</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Cornelia Robinson PANCOAST</u>		4. DATE OF DEATH Month Day Year <u>August 5, 1967</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>October 23, 1900</u>
9 AGE (In years lost birthday) <u>66</u> yrs		IF UNDER 1 YEAR Months Days Hours Min. <u>66</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER Public School</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Public School</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN Q. ROBINSON</u>		14 MOTHER'S MAIDEN NAME <u>ANNE E. BAERER</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>—</u>	
17 INFORMANT <u>JOHN L. PANCOAST</u>		Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <u>231X</u> IMMEDIATE CAUSE (a) <u>Brain Tumor</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>—</u>			
19 WAS A. TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>—</u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f (City or town) (County) (State) <u>—</u>
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>1957</u> , 19 <u>—</u> , to <u>August 5, 1967</u> , that (I) <u>(see)</u> lost saw the deceased alive on <u>8-5-67</u> , and that death occurred at <u>—</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>J. M. Shipley</u>		22b DATE SIGNED <u>8-7-67</u>	
22c PHYSICIAN'S NAME (Type) <u>J. M. SHIPLEY</u>		22d ADDRESS <u>ANNAPOLIS MD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>8-8-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>	23d LOCATION (City or Town) (County) (State) <u>ANNAPOLIS MD.</u>
24. FUNERAL DIRECTOR <u>John M. Taylor & Sons, Annapolis, Md.</u>		25a REC'D BY REGISTRAR DATE <u>AUG 8 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10494

10492

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 12 Oak Court	
3. NAME OF DECEASED (Type or print) First Middle Last Otto (none) PARKINSON		4. DATE OF DEATH Month Day Year August 12 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1905
9. AGE (In years last birthday) 62 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD		10b. KIND OF BUSINESS OR INDUSTRY State of MD.	
11. BIRTHPLACE (County & State, or foreign country) Annapolis Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GEORGE PARKINSON		14. MOTHER'S MAIDEN NAME HANNIE LEE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT GOLDIE M. PARKINSON		Address #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Poly cystic kidneys DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 1967 Aug. 12 10:10 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (do not) attended the deceased from 1960 to Aug. 12, 1967 , that (I) (do not) saw the deceased alive on Aug. 12, 1967 , and that death occurred at 5 A.M. from causes and on the date stated above.			
22a. SIGNATURE Frank M. Shipley		22b. DATE SIGNED 8-14-67	
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley, M.D.		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-15-67	
23c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF		23d. LOCATION (City or Town) (County) (State) Annapolis A.H. Md.	
24. FUNERAL DIRECTOR John M. Lyons & Sons Annapolis, Md.		25a. REC'D BY REGISTRAR DATE AUG 16 1967	
25b. REGISTRAR'S SIGNATURE John M. Lyons			



10495

CERTIFICATE OF DEATH

10493

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb 0 0 A	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		e. STREET ADDRESS 186 - 11th St.	
3 NAME OF DECEASED (Type or print) JACOB R. PIKE		4 DATE OF DEATH Month August Day 12 Year 19 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/23/91
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dept. of Sanitation		10b. KIND OF BUSINESS OR INDUSTRY Balto. City	
11 BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Pike		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 2 18-50-5574	
17. INFORMANT Nevelyn Windsor, dght, above		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 1810 DUE TO Fibrosis and emphysema of lungs (b) DUE TO Carcinoma of parotid gland (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS A T.O.P.S.Y. PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/16 , 19 66 , to Aug 12 , 19 67 , that (I) (we) last saw the deceased alive on June 8 , 19 67 , and that death occurred at 11 A M, from causes on and on the date stated above.			
22a. SIGNATURE Joseph Taler		22b. DATE SIGNED 8/11/67	
22c. PHYSICIAN'S NAME (Type) JOSEPH TALER		22d. ADDRESS 95 Appahart Rd. Glen Burnie Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/16/67	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Schimmek Funeral Home, Inc.		25a. REC'D BY REGISTRAR AUG 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

10496

Item #12 Film #G392

CERTIFICATE OF DEATH

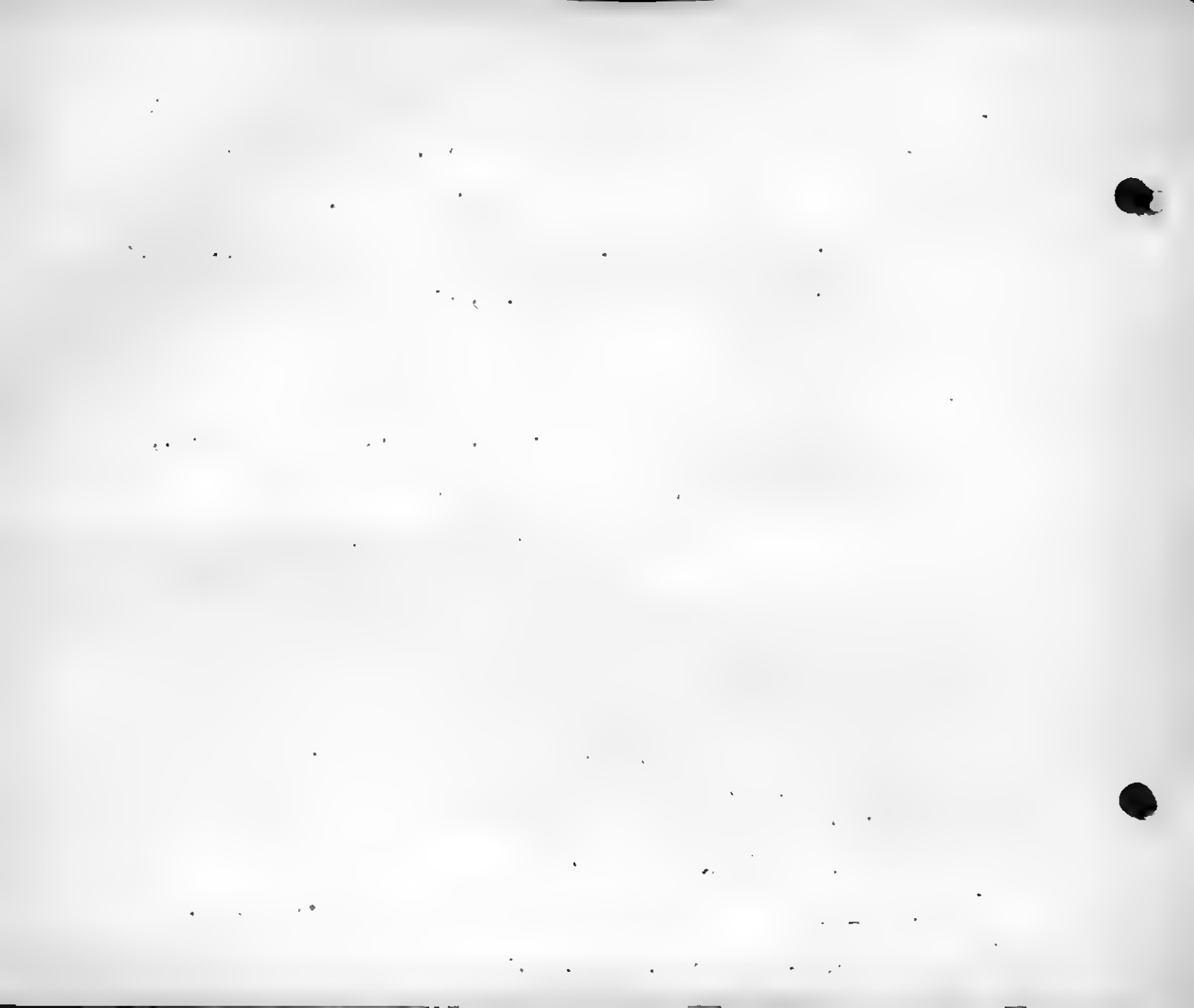
Reg. Dist. No.

10494

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Heights				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore BROOKLYN HEIGHTS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4411 4th STREET				d. STREET ADDRESS 4411 4th St.			
3. NAME OF DECEASED (Type or print) First Rose Middle G. Last Pollock				4. DATE OF DEATH Month Aug. Day 27 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1, 1883		9. AGE (In years last birthday) yrs. 84	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? Ireland
13. FATHER'S NAME Peter Grant				14. MOTHER'S MAIDEN NAME Mary Fitzimmons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. XXXXXXXX		Address Gerald P. Pollock, 406 Orchard Ave.,		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 19 67 to August 19 67 ; that I last saw the deceased alive on August 11, 1967 and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Mario J. Reda				M.D. 4016 RITCHIE HWY			
PHYSICIAN'S NAME (Type) MARIO J. REDA M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-29-67		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Fleming				ADDRESS 1222 Light St. Balt. Md. 30		24a. REC'D BY REGISTRAR DATE AUG 29 1967	
				24b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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1-2

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1049.

10495

1 PLACE OF DEATH a COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Anne Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c LENGTH OF STAY IN 1b 7 days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d STREET ADDRESS Box-422	e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Annie Middle PORTER Last PORTER		4 DATE OF DEATH Month August Day 11 Year 19 67	
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED XX DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11/4/86
9 AGE (in years last birthday) 80 yrs		F UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Unknown		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT Violet Torney 1306 Upton St.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Large size heart failure DUE TO (b) Angiocarditis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH Days Yes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Malnutrition			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) physician attended the deceased from 8/2 , 19 67 , to Aug. 10 , 19 67 , that (I) did saw the deceased alive on Aug. 10 , 19 67 , and that death occurred at 1:00 AM , from causes and on the date stated above			
22a SIGNATURE Gerard Oberhel M.D.		22b DATE SIGNED 8/12/67	
22c PHYSICIAN'S NAME (Type) Gerard Oberhel		22d ADDRESS 121 Cathedral St., Annapolis, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	8/15/67	Town Neck	Arundel Co., Maryland
24. FUNERAL DIRECTOR Charles A. Rice 661 W. Barre St.		25a REC'D BY REGISTRAR DATE AUG 16 1967	25b REGISTRAR'S SIGNATURE St. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
10498									
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shadyside				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Isabelle Sarah PROCTOR					4. DATE OF DEATH Month August Day 28 Year 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1, 1901		9. AGE (In years lost birthday) 66 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State or foreign country) Shadyside Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Harrison H Rogers					14. MOTHER'S MAIDEN NAME Annie Hallock				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO		17. INFORMANT Robert A Proctor Shadyside Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Antero-lateral myocardial infarction 4201 DUE TO (b) Hypertensive cardiovascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 1/2 years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus, severe, uncontrolled									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan 1960 , 19 to Aug 28 , 1967, that (I) (we) last saw the deceased alive on Aug 28, 1967 , and that death occurred at 9:00 P.M. from causes and on the date stated above.									
22a. SIGNATURE Willard F. Smith					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/29/67
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Aug 31 1967		23c. NAME OF CEMETERY OR CREMATORY Duck Creek			23d. LOCATION (City or Town) (County) (State) Lidlesville HA Md		
24. FUNERAL DIRECTOR Bernard Handberg					25a. REC'D BY REGISTRAR Charles J. Jones		25b. REGISTRAR'S SIGNATURE Charles J. Jones		
DATE AUG 31 1967									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10493

10497

1 PLACE OF DEATH a COUNTY <u>H.A. CO</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <u>MD</u> b COUNTY <u>AA CO</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c LENGTH OF STAY IN 1b <u>Annapolis</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA - Anne Arundel - General</u>		d STREET ADDRESS <u>29 Johnson Place</u>	
3 NAME OF DECEASED (Type or print) <u>James Randall</u>		4 DATE OF DEATH Month <u>8</u> Day <u>23</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>N</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-10-12</u>
9 AGE (In years last birthday) <u>55</u> yrs		IF UNDER 1 YEAR Months <u>8</u> Days <u>23</u> Hours <u>19</u> Min <u>67</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11 BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>John Randall</u>		14 MOTHER'S MAIDEN NAME <u>Frances Whittington</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>21216-2815</u>	
17 INFORMANT <u>Sarah Randall Anna M.D.</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4344</u> DUE TO (b) <u>Cardiac disease</u> DUE TO (c) <u>Sudden</u>			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4344</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>19</u> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		22. DATE SIGNED <u>8/23/67</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BIRTH, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>8-28-67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Pine Lawn</u>		23d LOCATION (City or town) (County) (State) <u>Annapolis MD</u>	
24 FUNERAL DIRECTOR <u>William Reese</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Annapolis</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>AUG 25 1967</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (9)
6M 1/67

FOR STATE
HEALTH DEPT.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10500

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10498

1 PLACE OF DEATH a. COUNTY <u>Annapolis</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Annapolis</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>H.O.A. General</u>		e. STREET ADDRESS <u>210 Bestgate Rd</u>	
3 NAME OF DECEASED (Type or print) <u>Cynthia Lee Reed</u>		4 DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (in years last birthday) <u>9-25-1960</u>
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b KIND OF BUSINESS OR INDUSTRY	
10a BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		10b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11 FATHER'S NAME <u>Freddie C. Reed</u>		12 MOTHER'S MAIDEN NAME <u>Constance Saroy</u>	
13 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		14 SOCIAL SECURITY NO	
15 INFORMANT <u>Constance Reed Annapolis, Md</u>		16 ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by Car</u>	
20c TIME OF INJURY Month <u>8</u> Day <u>20</u> Year <u>1967</u>		20d INJURY OCCURRED While <input type="checkbox"/> of work Not While <input checked="" type="checkbox"/> of work	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Highway</u>		20f (City or town) (County) (State) <u>Annapolis MD</u>	
21. I certify that I took charge of the remains described above. Held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhart</u>		22. DATE SIGNED <u>8/20/67</u>	
EXAMINER'S NAME (Type) <u>E. Linhart</u>		M.D. <u>Charles Judge</u>	
23a USUAL REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>8-24-67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Mitchellville Md</u>		23d LOCATION (City or town) (County) (State)	
24 FUNERAL DIRECTOR <u>William Reese # Annapolis</u>		25a REC'D BY REGISTRAR <u>AUG 23 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c ADDRESS (Street, city, town, or county)	

CERTIFICATE OF DEATH

10499

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b Box 187 Rt. 5, Pasadena,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hosp.		d. STREET ADDRESS Box 187 Rt. 5, Pasadena,	
3 NAME OF DECEASED (Type or print) CHARLES G. REUWER		4. DATE OF DEATH Month Aug. Day 20 Year 19 67	
5 SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-5-10
9 AGE (n years last birthday) yrs. 56		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrician	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles J. Reuver		14. MOTHER'S MAIDEN NAME Mary Humphries	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 212-05-2611	
17. INFORMANT Dois L Reuver		Address Pasadena - Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Postero-lateral M.I. DUE TO A.S.H.D Condit ions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A.S.H.D DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Hours Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/28/1967 , to 8/20/1967 , that (I) (we) last saw the deceased alive on 8/20/1967 , and that death occurred at 10:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Dr. Armand M. J.		22b. DATE SIGNED 8/20/1967	
22c. PHYSICIAN'S NAME (Type) ADNAN SONMEZ		22d. ADDRESS 1011 Frederick Road, 21228 Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-23-1967	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City or Town) (County) (State) Baltimore Md
24. FUNERAL DIRECTOR Edw. S. MacKath Jr.		25a. REC'D BY REGISTRAR 301 Frederick Rd - 28	
25b. REGISTRAR'S SIGNATURE James J. Jones		DATE AUG 23 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10502 CERTIFICATE OF DEATH 10500									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>4</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middleburg Md</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Knollwood Manor</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Collingswood S. Roberts</u>					4. DATE OF DEATH <u>8-14-67</u> 19 <u>67</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 7-1890</u>		9. AGE (In years last birthday) <u>76</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13. FATHER'S NAME <u>Andrew</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Dr. R. H. Allen</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <u>4221 Congestive Heart Failure</u>		DUE TO (b) <u>Unmed</u>		DUE TO (c) <u>A.C.V.D.</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , 19 <u>57</u> to <u>1961</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8-13-67</u> , 19 <u>67</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>Robert R. Allen M.D.</u>		22b. DATE SIGNED <u>8-14-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Robert R. Allen M.D.</u>	
22d. ADDRESS <u>P.O. Box 73 Severna Park</u>		23a. BURIAL, CREMATION, or other disposition <u>Cremation</u>		23b. DATE THEREOF <u>8-15-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Frederick Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Frederick Md</u>	
24. FUNERAL DIRECTOR <u>Charles Judge</u>		ADDRESS <u>Frederick Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 16 1967</u>	

CERTIFICATE OF DEATH

10503

10501

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 22 Maryland Ave.,	
3. NAME OF DECEASED (Type or print) Ina Althea ROSS		4. DATE OF DEATH Month August Day 8 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 22, 1885
9. AGE (in years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher Public Schools		10b. KIND OF BUSINESS OR INDUSTRY Westernport, Md.	
11. BIRTHPLACE (County & State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME William T. Ross		14. MOTHER'S MAIDEN NAME Elizabeth Jenkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Gastric intestinal hemorrhage DUE TO (b) Peptic ulcer DUE TO (c) Subcapsular Ex. Sup. Left Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
INTERVAL BETWEEN ONSET AND DEATH 24 hrs 3 w			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour "a.m." 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) physician attended the deceased from Aug. 8, 1967 to Aug. 8, 1967 that (I) was last saw the deceased alive on Aug. 8, 1967 , and that death occurred at Aug. 8, 1967 M, from causes and on the date stated above.			
22a. SIGNATURE George W. Settle		22b. DATE SIGNED 8-9-67	
22c. PHYSICIAN'S NAME (Type) George W. Settle, MD.		22d. ADDRESS 102 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 8-10-1967	23c. NAME OF CEMETERY OR PREMATORY Philos Cemetery	23d. LOCATION (City or Town) (County) (State) Westernport Md.
24. FUNERAL DIRECTOR John M. Layton Sons Annapolis, Md.		25a. REC'D BY REGISTRAR DATE AUG 11 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



10504

CERTIFICATE OF DEATH

10502

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>A. A. Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FERRY FARMS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FERRY FARMS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>CAIN</u> Last <u>RUKE</u>		4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-16-1904</u> 63 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MIDDLEBUSH N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JUDSON V. CAIN</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN DRAVTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>MRS. THOMAS T. MILLER #12</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <u>Atherosclerotic Heart Disease</u> (c) <u>Under</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-66</u> , 19 <u>67</u> to <u>8-17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-17</u> , 19 <u>67</u> , and that death occurred at <u>undetermined</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>W.P. Stephens</u>		22b. DATE SIGNED <u>8-26-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.P. STEPHENS</u>		22d. ADDRESS <u>CORN HILL ST. ANNAPOLIS</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>8-26-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>	23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG MD.</u>
24. FUNERAL DIRECTOR <u>John M. & Mary Lou Lewis Church, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 29 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

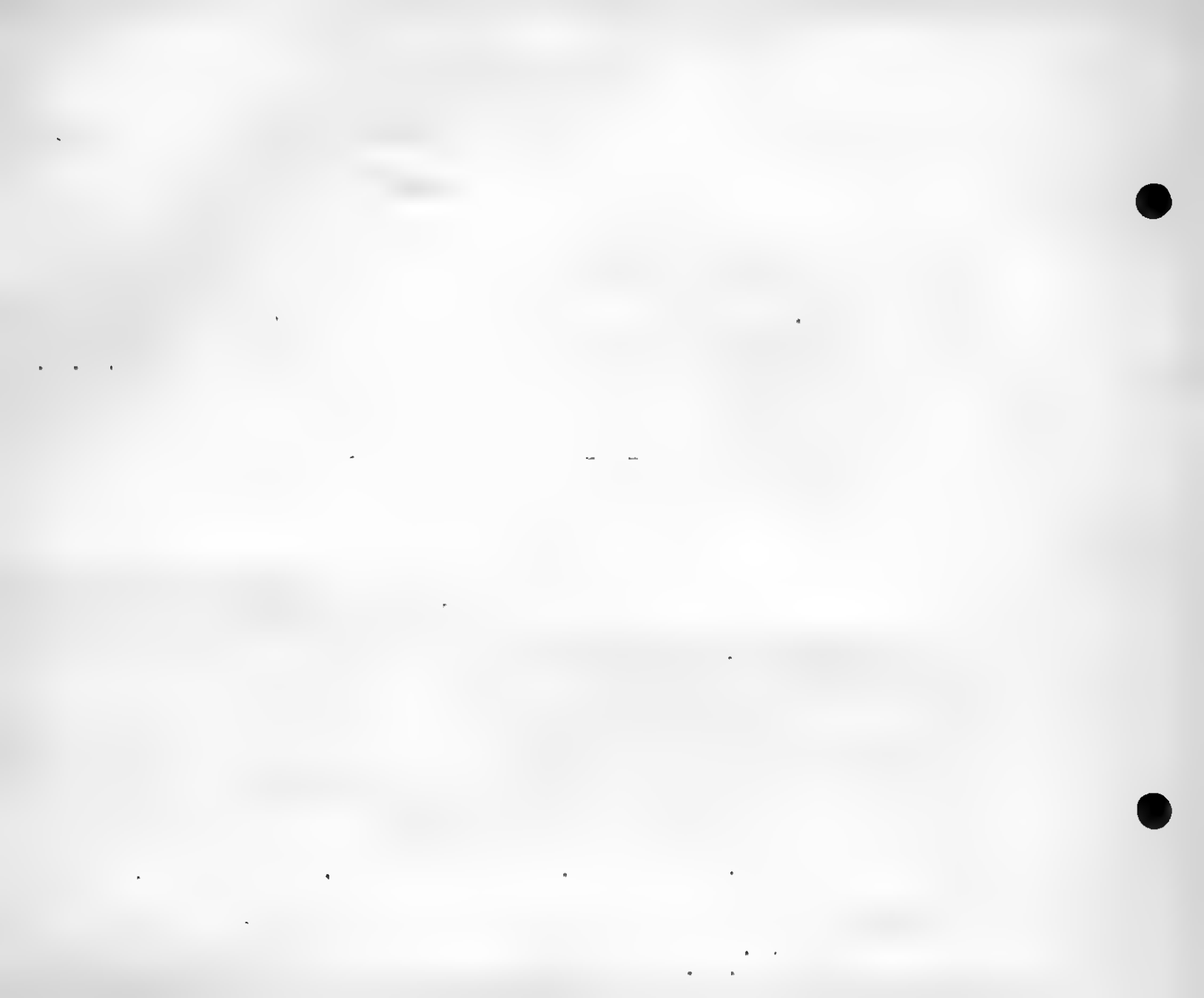
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10505

CERTIFICATE OF DEATH

10503

1 PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 12 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo d. STREET ADDRESS Box 16 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3 NAME OF DECEASED (Type or print) Louis Henry SCHAUMLEFFLE			4. DATE OF DEATH August 29, 1967		
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 25, 1896		9. AGE (In years last birthday) 71 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-printer-Government Printing Office			10b. KIND OF BUSINESS OR INDUSTRY Illinois		11. BIRTHPLACE (County & State, or foreign country) U. S. A.
13 FATHER'S NAME William Schaumleffle			14. MOTHER'S MAIDEN NAME Louisa Muth		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes 1920-23		16. SOCIAL SECURITY NO. 578-46-2685A	17. INFORMANT Betty J. Schaumleffle same as #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO (b) Pontine infarction DUE TO (c) Thrombosis, arterial, branch not specified Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332X					INTERVAL BETWEEN ONSET AND DEATH 4 minutes 9 days 9 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atrial fibrillation, hypertension, chronic bronchitis					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21 I certify that (I) (this hospital) attended the deceased from Jun 22, 1966 , to Aug 29, 1967 , that (I) (we) last saw the deceased alive on Aug 29, 1967 , and that death occurred at 2:30 p.m. from causes and on the date stated above					
22a. SIGNATURE Charles W. Kinzer			22b. DATE SIGNED Aug 30, 1967		
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.			22d. ADDRESS 16 Murray Av., Annapolis, Md. 21401		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 9/5/67	23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	23d. LOCATION (City or Town) (County) (State) Fresno, California		
24 FUNERAL DIRECTOR The S.H. Hines Company 2901 14th St. N.W. Washington, DC			25a. REC'D BY REGISTRAR SEP 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge



10506

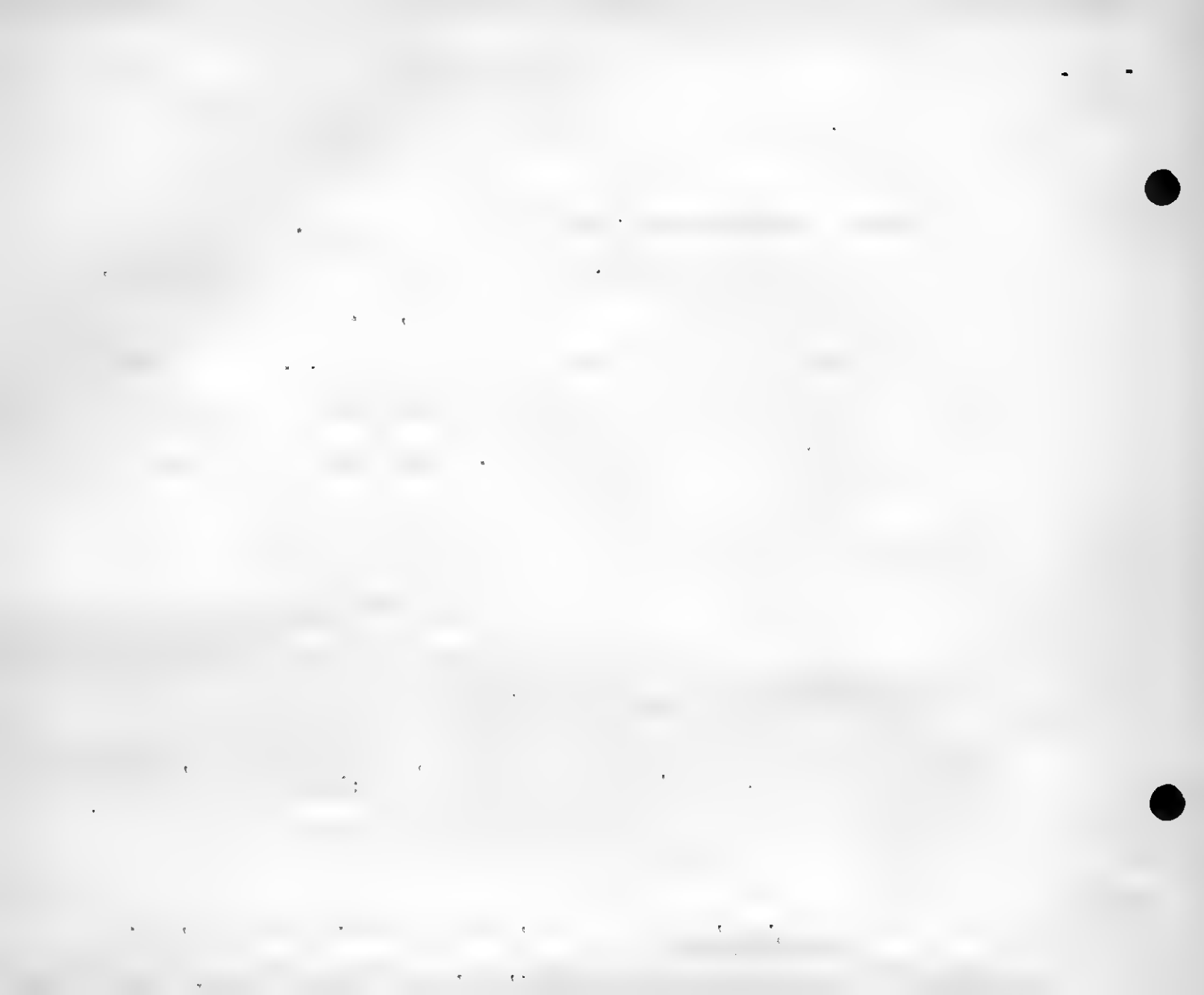
CERTIFICATE OF DEATH

10504

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
c. LENGTH OF STAY in 1b 1 Month		d. STREET ADDRESS 209 Baylor Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Knollwood Manor Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY F. SCHMID		4. DATE OF DEATH Month August Day 9 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 27, 1892
9. AGE (In years last birthday) yrs 74		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Ret)		10b. KIND OF BUSINESS OR INDUSTRY Civil Service	
11. BIRTHPLACE (County & State, or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Schmid		14. MOTHER'S MAIDEN NAME Henretta Overmann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-1		16. SOCIAL SECURITY NO 262-84-8718	
17. INFORMANT Mrs. Alice Schmid		Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Left Ventricular failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 271A DUE TO (b) Congestive heart failure DUE TO (c) Blood dyscrasia		INTERVAL BETWEEN ONSET AND DEATH hours hours years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cachexia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 3, 1967 , to August 9, 1967 , that (I) (we) last saw the deceased alive on August 9, 1967 , and that death occurred at 2:15 P.M. from causes and on the date stated above			
22a. SIGNATURE Max C Frank		22b. DATE SIGNED 8/9/67	
22c. PHYSICIAN'S NAME (Type) MAX C FRANK MD		22d. ADDRESS 425 5th Avenue - Hy Glen Burnie	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Aug. 11, 1967	
23c. NAME OF CEMETERY OR CREMATORY Baltimore, National Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Robert Plume		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE AUG 11 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

10507

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10505

1 PLACE OF DEATH a COUNTY Anne Arundel MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Anne Arundel			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shadyside		c LENGTH OF STAY IN lb		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shadyside			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shadyside, Maryland				d STREET ADDRESS Shadyside, Maryland		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Baby				4 DATE OF DEATH Schmitt		5 DATE August 14, 1967	
6 SEX Male	7 COLOR OR RACE White	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 DATE OF BIRTH July 31, 1967	10 AGE (In years last birthday) yrs 15	11 IF UNDER 1 YEAR Months Days Hours Min		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Annapolis, A.A.Co.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Clarence Bernard Schmitt				14 MOTHER'S MAIDEN NAME Marian June Martin			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.		17 INFORMANT		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Interstitial Pneumonitis (SDII) DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)				22. DATE SIGNED 8/14/67	
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE THEREOF 8/28/67		23c NAME OF CEMETERY OR CREMATORY Waf mal		23d LOCATION (City or town) (County) (State) BALTIMORE Md.	
24 FUNERAL DIRECTOR				25a REC'D BY REG STRAR AUG 29 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

10505

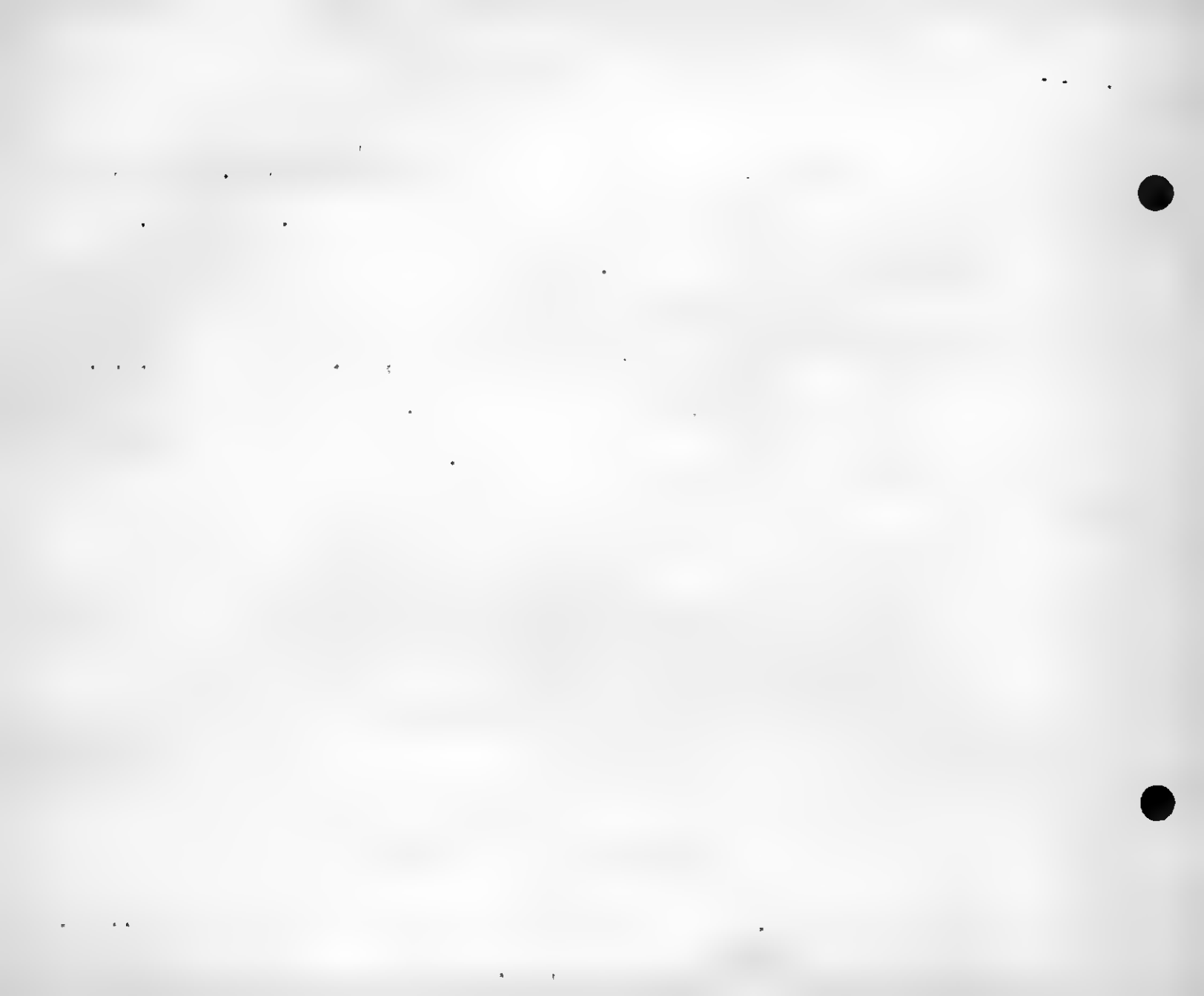
CERTIFICATE OF DEATH

10506

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie (XXXXXXXXXX)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS 481 Monterey Ave. Odenton Md.	
3. NAME OF DECEASED (Type or print) First Edith Middle J. Last Schofield		4. DATE OF DEATH Month August Day 29 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-31-87
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Manufacturing	
11. BIRTHPLACE (County & State, or foreign country) Harmons, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hezekiah Jeffrey		14. MOTHER'S MAIDEN NAME Sarah Wade	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220 14 1852 A	
17. INFORMANT Mrs. Edith McDonnell (daughter)		Address same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO (b) Sclerotic Cardio Vascular Disease DUE TO (c) Hypertensive Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1967, to 8/29, 1967, that (I) (we) last saw the deceased alive on 8/29, 1967, and that death occurred at 2:16 P.M. from causes and on the date stated above.			
22a. SIGNATURE Jels Freuler		22b. DATE SIGNED 8/29/67	
22c. PHYSICIAN'S NAME (Type) Hebus G. Gunberg		22d. ADDRESS 1113 Odenton Rd Odenton	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 1/67	
23c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery		23d. LOCATION (City or Town) (County) (State) Anne Arundel Co., MD.	
24. FUNERAL DIRECTOR R. Singleton		25a. REC'D BY REGISTRAR OATE SEP 6 1967	
25b. REGISTRAR'S SIGNATURE John C. Judge			

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY A.A. Co. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN It		2 USUAL RESIDENCE (Where deceased lived, if not last on Residence before admission) a. STATE MD b. COUNTY AA CO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie SEVERN 02.1	
3 NAME OF DECEASED (Type or print) CHARLES E. Scott		4 DATE OF DEATH Month 8 Day 25 Year 1967	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W-DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/10/1941
9 AGE (In years, last birthday) 25 yrs		10 IF UNDER 1 YEAR Months 1 Days 15 Hours 1 Min 0	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHEET METAL WORKER		12 CITIZEN OF WHAT COUNTRY U.S.A.	
13 FATHER'S NAME CHARLES SCOTT		14 MOTHER'S MAIDEN NAME LILLIAN RHOADES	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO 219.38.581	
17 INFORMANT CHARLES SCOTT 7809 OAKWOOD RD		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) multiple injuries DUE TO 011.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 011.4 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Car struck fence object	
20c TIME OF INJURY Month Day Year Hour 8 pm 8/25/67		20d INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Highway		20f (City or town) (County) (State) AA CO MD	
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. Lowhard EXAMINER'S NAME (Type)		22. DATE SIGNED 8/25/67	
23a BURIAL CREMATION REMOVAL (Specify)		23b DATE THEREOF	
Burial		8/28/67	
23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or town) (County) (State)	
Holy Cross Cemetery		Brooklyn, Md.	
24 FUNERAL DIRECTOR Raymond C. Fink		25a REC'D BY REG. CLERK AUG 31 1967	
Glen Burnie, Md.		25b REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 12 hours after death.

VR A15ME (5)
GM 1/66

10510

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10508

1 PLACE OF DEATH a COUNTY <u>A.A. CO.</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD</u> b COUNTY <u>AACO.</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c LENGTH OF STAY in 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		d IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A.-North ARUNDEL-Hosp.</u>				d STREET ADDRESS <u>7809 Oakwood Rd</u>			
3 NAME OF DECEASED (Type or print) <u>Joseph P Scott</u>				4 DATE OF DEATH Month <u>8</u> Day <u>25</u> Year <u>19 67</u>			
5 SEX <u>M</u>		6 COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>9/14/46</u>	
9 AGE (In years lost birthday) <u>20</u> yrs		10 UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		11 BIRTHPLACE (State or foreign country) <u>Glen Burnie</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker Heating</u>				10b KIND OF BUSINESS OR INDUSTRY			
13 FATHER'S NAME <u>CHARLES SCOTT</u>				14 MOTHER'S MAIDEN NAME <u>LILLIAN RHOADES</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO		17 INFORMANT <u>CHARLES SCOTT - 7809 Oakwood Rd.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY <u>19.4</u> IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Car struck front of leg</u>					
20c TIME OF INJURY Month, Day, Year Hour <u>11</u> pm <u>5/25</u> 19 <u>67</u>		20d INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f (City or town) (County) (State) <u>AACO MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u> </u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>8/28/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Brooklyn, Md.</u>	
24 FUNERAL DIRECTOR <u>Raymond C. Fink</u>				25a REC'D BY REGISTRAR <u>AUG 31 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10511

CERTIFICATE OF DEATH

10509

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel, Hospital Drive		d. STREET ADDRESS Box 248, Rt. 6, Mt. Pleasant Dr.	
3 NAME OF DECEASED (Type or print) First Arthur Middle A. Last Sesnie		4. DATE OF DEATH Month August Day 24 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 30, 1905
9. AGE (In years last birthday) 62 yrs		IF UNDER 1 YEAR Months 6 Days 24 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State or foreign country) Brooklyn, New York USA		12. CITIZEN OF WHAT COUNTRY? U S. A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16 SOCIAL SECURITY NO. Unknown	
17 INFORMANT Hank Renoetowize		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Disease DUE TO (b) Laennec's Cirrhosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Intraperitoneal Malignancy			INTERVAL BETWEEN ONSET AND DEATH
PART II - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cholelithiasis			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/21 , 19 67 to 8/24 , 19 67 that (I) (we) last saw the deceased alive on 8/24 , 19 67 and that death occurred at 8/24 M, from causes and on the date stated above			
22a SIGNATURE George Vash, M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) George Vash, M.D.		22d. ADDRESS 206 S. Gilmore St., Baltimore	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/26/67	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.
24. FUNERAL DIRECTOR Raymond C. Fink		25a. REC'D BY REGISTRAR AUG 31 1967	
25b. REGISTRAR'S SIGNATURE William J. Judge			

10512

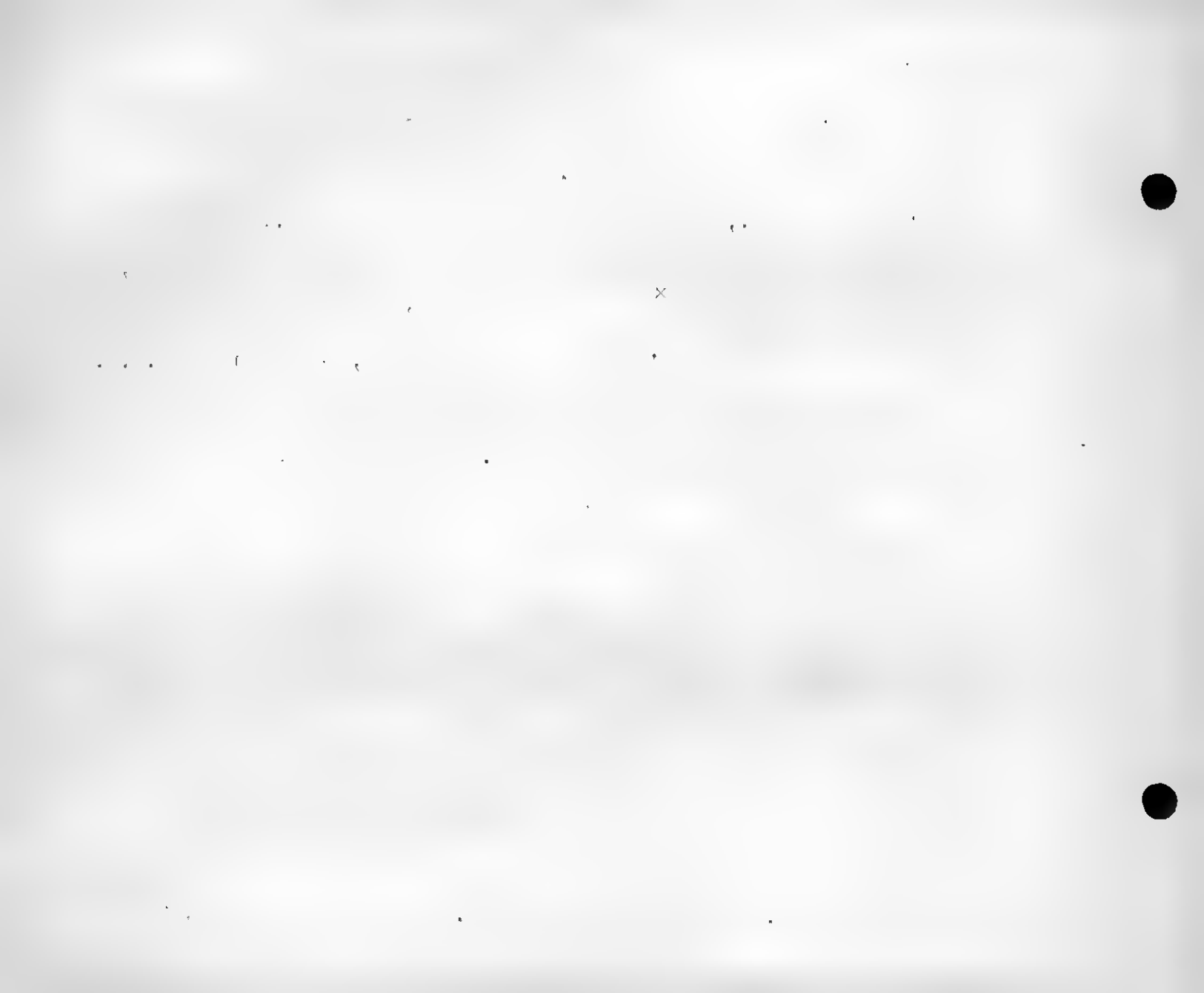
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			c. LENGTH OF STAY IN lb 41 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) #1304 Glen Ave., Ferndale				d. STREET ADDRESS #1304 Glen Ave., Ferndale		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) EUGENE (nm1) SHARE				4 DATE OF DEATH AUGUST 30, 1967			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 16, 1905	9 AGE (In years last birthday) 62 yrs	10 IF UNDER 1 YEAR Months Days Hours Min		11 IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Rice's Bakery		11 BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Benjamin Share				14. MOTHER'S MAIDEN NAME Bertha Ubanski			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 216 07 9717		17. INFORMANT Address Mrs. Marie Share (wife) Same As #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Bronchitis DUE TO (c) Carcinoma of lung							INTERVA. BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 5:55 AM , from causes and on the date stated above.							
22a. SIGNATURE Frank Groll				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Frank Groll, M.D.				22d. ADDRESS 108 Central Ave., Glen Burnie			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 2/67		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR R.V. Singleton				25a. REC'D BY REGISTRAR SEP 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10513

10511

1 PLACE OF DEATH a. COUNTY <i>Al. Al.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Al. Al.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Campanopolis</i>		c. LENGTH OF STAY IN IB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Al. Al. General</i>		d. STREET ADDRESS <i>1190 Bely Court</i>	
3 NAME OF DECEASED (Type or print) <i>Beatrice Ovella Simms</i>		4. DATE OF DEATH Month <i>8</i> Day <i>2</i> Year <i>1967</i>	
5 SEX <i>Female</i>	6 COLOR OR RACE <i>Crt.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-31-1913</i>
9. AGE (In years last birthday) <i>53</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS Hours <i>0</i> Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Inye</i>		14. MOTHER'S MAIDEN NAME <i>May E. Larkin</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>204-38-2248</i>	
17. INFORMANT <i>Wesley Johnson</i>		Address <i>Campanopolis</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <i>Cerebral aneurysm</i>			
DUE TO (b) <i>Hypertensive Cerebro Vascular</i>			
DUE TO (c) <i>with Cerebral aneurysm</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <i>0</i> m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>8-11-66</i> , 19 <i>8-2-67</i> , to <i>8-2-67</i> , that (I) (we) last saw the deceased alive on <i>8-1-67</i> , and that death occurred at <i>8-2-67</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>A. T. Allen</i>		22b. DATE SIGNED <i>8-5-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>A. T. ALLEN</i>		22d. ADDRESS <i>62 Colthard St</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		23b. DATE THEREOF <i>8/7/67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Pine Lawn</i>		23d. LOCATION (City or town) (County) (State) <i>Best Gate Co. Md.</i>	
24. FUNERAL DIRECTOR <i>William Reese #111111</i>		25a. REC'D BY REGISTRAR <i>AUG 4 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>James J. Jones</i>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY M.A. Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE MD b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GEN DORNIE		c. LENGTH OF STAY IN MD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. - North BRUNDEL Hosp.		e. STREET ADDRESS 7 MAPLE AVENUE	
3. NAME OF DECEASED (Type or print) Ruth Roehle		4. DATE OF DEATH 5 MAY 15 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/25/30
9. AGE (in years last birthday) 17		10. FUNDING 1 YEAR 17 MONTHS 15 DAYS 15 HOURS 15 MIN	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Charles Smay		14. MOTHER'S MAIDEN NAME Ethel Roehle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT Mr. Charles Smay, 7 Maple Ave., Ellicott City, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries (b) 1944 (c) Due to			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I of Item 18) Car struck fence	
20c. TIME OF INJURY Month, Day, Year 8/25 1967		20d. INJURY OCCURRED <input type="checkbox"/> While at work <input checked="" type="checkbox"/> Not While at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) AA CO (County) MD (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. Linhardt		22. DATE SIGNED 8/25/67	
EXAMINER'S NAME (Type) E. LINHARDT		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		24. BURLING REMOVAL (Specify) Burial	
24b. DATE THEREOF Aug. 28, 1967		24c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24d. LOCATION (City or Town) Baltimore, Md.		25a. REC'D BY REGISTRAR AUG 29 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10513

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b Severn Rt. 2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First ROBERT Middle E Last SMITH		4 DATE OF DEATH Month August Day 3 Year 1967	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 10/27/1934
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) 32 yrs IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min 0
11 BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Robert E. Smith Sr.		14 MOTHER'S MAIDEN NAME Bessie Thomas	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16 SOCIAL SECURITY NO	
17 INFORMANT Bessie Smith-Richmond, Va.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Indetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		22. DATE SIGNED August 3, 1967	
EXAMINER'S NAME Type) Charles S. Springate, M.D.		Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 8/7/67	23c. NAME OF CEMETERY OR CREMATORY Glendale Natl. Cemetery	23d. LOCATION (City or town) (County) (State) Richmond, Va.
24. FUNERAL DIRECTOR William Reese, Jr. - Anna, Md.		25a. REC'D BY REGISTRAR 4 1967	
25b. REGISTRAR'S SIGNATURE Charles J. Jones			

CERTIFICATE OF DEATH

10516

10514

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove containing papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>24 JEFFERSON PLACE</u>		d. STREET ADDRESS <u>24 JEFFERSON PLACE</u>	
3 NAME OF DECEASED (Type or print) <u>Sadie E. SNYDER</u>		4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1967</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 10, 1876</u>
9 AGE (In years last birthday) <u>91</u> yrs.		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
10b KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>	
12 CITIZEN OF WHAT COUNTRY <u>US</u>		13 FATHER'S NAME <u>JOHN SPRANKLE</u>	
14 MOTHER'S MAIDEN NAME <u>SARAH MATILDA COOK</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16 SOCIAL SECURITY NO. <u>-</u>		17 INFORMANT Address <u>AUGUSTUS K. SNYDER #2</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchitis</u> 526X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ACVD</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>8-24, 1967</u> , that (I) (we) last saw the deceased alive on <u>8-24, 1967</u> , and that death occurred at <u>12 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Frank M. Shipley</u>		22b. DATE SIGNED <u>8-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frank M. Shipley, M.D.</u>		22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8-26-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS MD</u>
24 FUNERAL DIRECTOR ADDRESS <u>JOHN M. TAYLOR - SONS ANNAPOLIS MD</u>		25a. REC'D BY REGISTRAR <u>AUG 28 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10517

CERTIFICATE OF DEATH

10515

1. PLACE OF DEATH a. CITY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if at institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 15 <u>16</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d. STREET ADDRESS <u>2411 Rambilin Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Francesco P. Sortino</u>		4. DATE OF DEATH Month <u>August</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>wt.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-7-88</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>8</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cement</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Sortino</u>		14. MOTHER'S MAIDEN NAME <u>Concetta Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Vincent Di Leonardi</u>		Address <u>12311 Rambilin Lane</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Congestive heart failure</u> DUE TO (c) <u>Adrenal Failure & ASCITIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3-4</u> <u>4 months</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sunbathing situation</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>7/28/67</u> , 19 <u>67</u> , to <u>8/15/67</u> , 19 <u>67</u> , that (1) (we) lost saw the deceased alive on <u>8/15/67</u> , 19 <u>67</u> , and that death occurred at <u>11:50</u> PM, from causes and on the date stated above			
22a. SIGNATURE <u>David Abramson</u>		22b. DATE SIGNED <u>8/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>David Abramson MD</u>		22d. ADDRESS <u>702 Baltimore Blvd Glen Burnie Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8 19 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>	23d. LOCATION (City or Town) (County) (State) <u>Brooklyn, A. A. Co. Md.</u>
24. FUNERAL DIRECTOR <u>Mc Gully</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 18 1967</u>	
ADDRESS <u>130 E. Fort Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

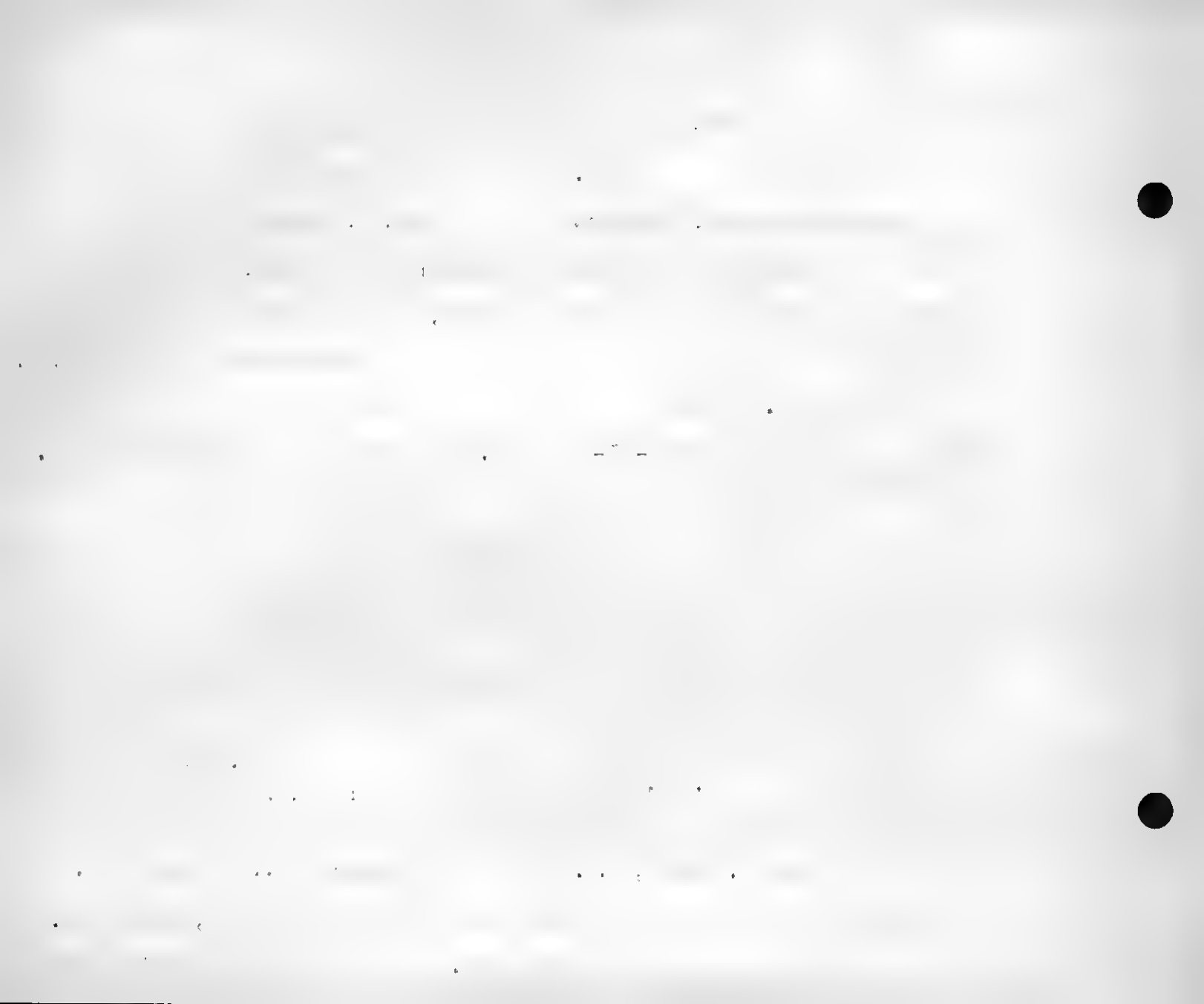
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
10518					10516				
CERTIFICATE OF DEATH									
1 PLACE OF DEATH a COUNTY Anne Arundel MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Anne Arundel				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c LENGTH OF STAY IN lb 1 day.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold - RURAL				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital					d STREET ADDRESS Rt. 2, Box 66			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Helen Kurtz STALLSMITH					4 DATE OF DEATH Month August Day 23 Year 1967				
5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH July 3, 1893		9 AGE (In years last birthday) yrs. 74	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) Pennsylvania			12 CITIZENSHIP OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME William H. Kurtz					14 MOTHER'S MAIDEN NAME Sarah Grove				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16 SOCIAL SECURITY NO 175-01-4407		17 INFORMANT Address Mr. Raymond Stallsmith, Arnold Md.				
18 CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung with cerebral metastases DUE TO (b) metastases DUE TO (c) metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 29m	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19			20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		
21 I certify that (I) (the hospital) attended the deceased from 1965 , 19 Aug. 23 , 19 67 that (I) did last saw the deceased alive on Aug. 23 , 19 67 , and that death occurred at 11:00 A.M. from causes and on the date stated above.									
22a SIGNATURE Richard N. Peeler			M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 8/23/67				
22c PHYSICIAN'S NAME (Type) Richard N. Peeler, M.D.			22d ADDRESS 121 Cathedral St., Annapolis, Md.						
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE THEREOF 8/26/1967		23c NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		23d LOCATION (City or Town) (County) (State) Gettysburg, Adams Co. Pa.		
24 FUNERAL DIRECTOR Boers & Munroe			ADDRESS Gettysburg, Pa.		25a REC'D BY REGISTRAR DATE AUG 28 1967		25b REGISTRAR'S SIGNATURE J. Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only one event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10519

CERTIFICATE OF DEATH

10517

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 61 Cornhill St.	
3 NAME OF DECEASED (Type or print) Olive Hall STEVENSON		4 DATE OF DEATH Month August Day 25 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 11, 1892
9 AGE (In years lost birthday) yrs. 75		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ANTIQUAIRE DEALER		10b. KIND OF BUSINESS OR INDUSTRY ANTIQUES	
11 BIRTHPLACE (County & State, or foreign country) England		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME JOHN HENRY HALL		14 MOTHER'S MAIDEN NAME LOUISA GRIFFITH	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT MILDRED S. ARNALL CROFTON MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchogenic Carcinoma DUE TO (b) 5 mm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Heart Disease			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) physician attended the deceased from Feb 1967 to 8-25, 1967 that (I) did saw the deceased alive on 8-24, 1967 , and that death occurred at 6:55 AM from causes and on the date stated above.			
22a SIGNATURE Frank M. Shipley		22b DATE SIGNED 8-25-67	
22c PHYSICIAN'S NAME (Type) Frank M. Shipley, M.D.		22d ADDRESS 121 Cathedral St., Annapolis, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 8-28-1967	
23c NAME OF CEMETERY OR CREMATORY ST. STEPHEN'S CEM.		23d LOCATION (City or Town) (County) (State) WATERBURY A.A. Co. MD	
24 FUNERAL DIRECTOR JOHN M. TAYLOR, 5015 ANNAPOLIS MD		25a REC'D BY REGISTRAR DATE AUG 28 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

10520

CERTIFICATE OF DEATH

10518

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 43 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 108 First Ave. S/W		d. STREET ADDRESS 108 First Ave. S/W	
3 NAME OF DECEASED (Type or print) First LOTTIE Middle J. Last STINCHCOMB		4. DATE OF DEATH Month August Day 3 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 July 1888
9. AGE (In years last birthday) 79 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10b. KIND OF BUSINESS OR INDUSTRY Own-Home	
11. BIRTHPLACE (County & State or foreign country) Anne Arundel Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Jenkins		14. MOTHER'S MAIDEN NAME Emma J. Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO -----	
17. INFORMANT Mrs. Geneva Boone-700 W/ Belvedere, Balto		Address 10, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypostatic pneumonia DUE TO Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 15, 1967 to Aug. 3, 1967 , that (I) (we) last saw the deceased alive on Aug. 3, 1967 , and that death occurred at 7:20 A.M. from causes and on the date stated above.			
22a. SIGNATURE B. A. de Guzman		22b. DATE SIGNED Aug. 4, 1967	22c. PHYSICIAN'S NAME (Type) B. A. de Guzman, M.D.
22d. ADDRESS 204 Crain Hwy. S. Glen Burnie, Md.		22e. REC'D BY REGISTRAR AUG 7 1967	
22f. REGISTRAR'S SIGNATURE Charles Judge		22g. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/5/1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery
23d. LOCATION (City or Town) Brooklyn RD		(County) (State) Maryland	
24. FUNERAL DIRECTOR Robert Paine		24b. ADDRESS Singleton Funeral Home/Glen Burnie, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

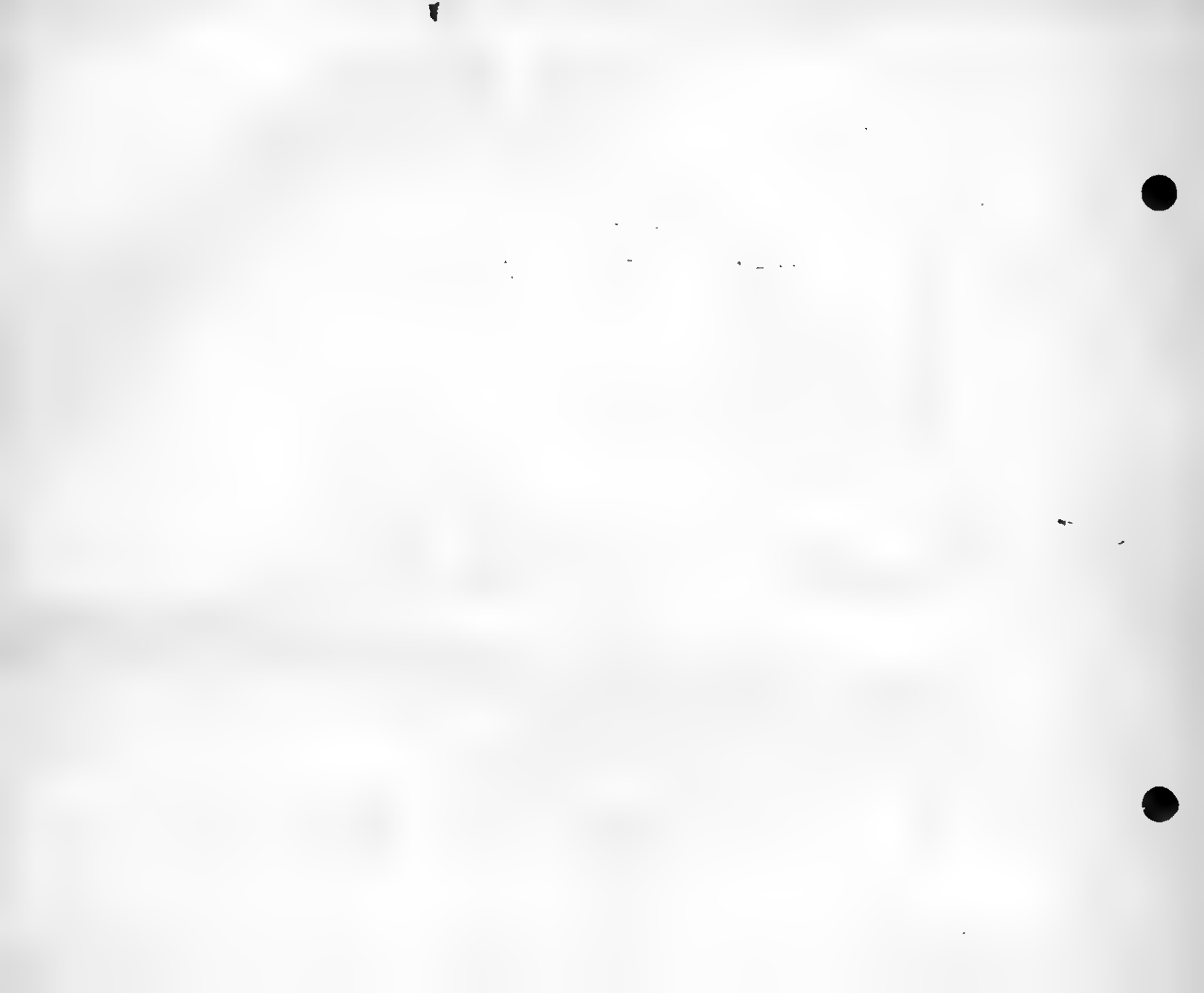
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

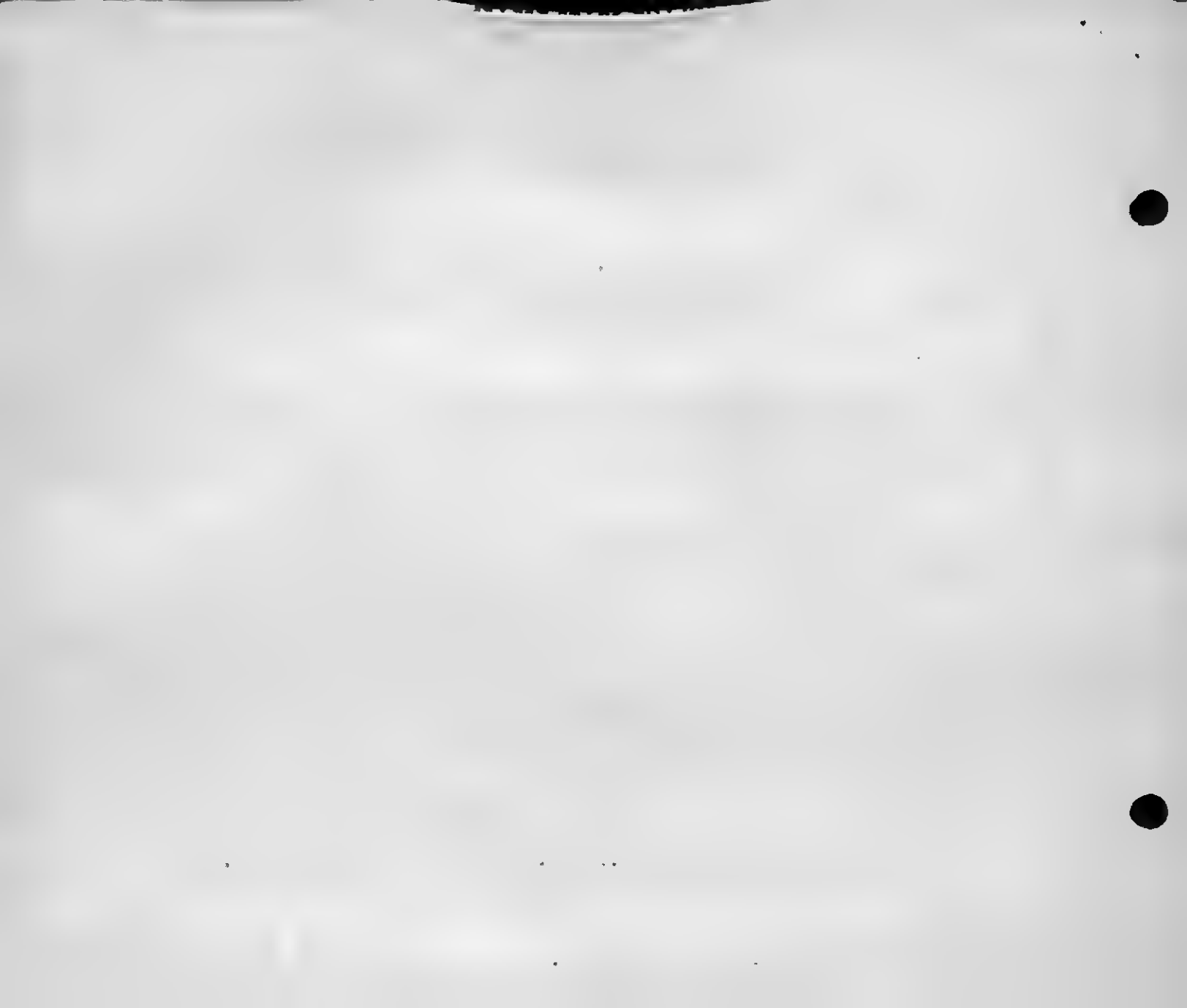
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 393 2-27-67		MARYLAND STATE DEPARTMENT OF HEALTH		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		10519	
10521		MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if at institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green Bernie</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>P.O.A. - NORTH ARUNDEL Hosp.</u>				d. STREET ADDRESS <u>Rt 3 - Box 300</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>I</u> Last <u>BUMPER</u>				4. DATE OF DEATH Month <u>8</u> - Day <u>25</u> - Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-23-21</u>	9. AGE (In years last birthday) <u>46</u> Yes	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>W. VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Warner Radcliff</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Canfield</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>Family</u>		Address <u>Gene</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: <u>11 Months</u> IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerosis Generalized</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>11 Months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Linhart</u> M.D.				22. DATE SIGNED <u>8/21/67</u>			
EXAMINER'S NAME (Type) <u>E. Linhart</u>				Address (Street, city, town, or county) <u>Severna Park, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-29-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Haven Cem.</u>		23d. LOCATION (City or town) (County) (State) <u>Severna Park, Md.</u>	
24. FUNERAL DIRECTOR <u>Robert S. Banerco Funeral Home - Severna Park, Md.</u>				25a. REC'D BY REGISTRAR <u>AUG 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



VR A15 (4)
20M 5-63



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

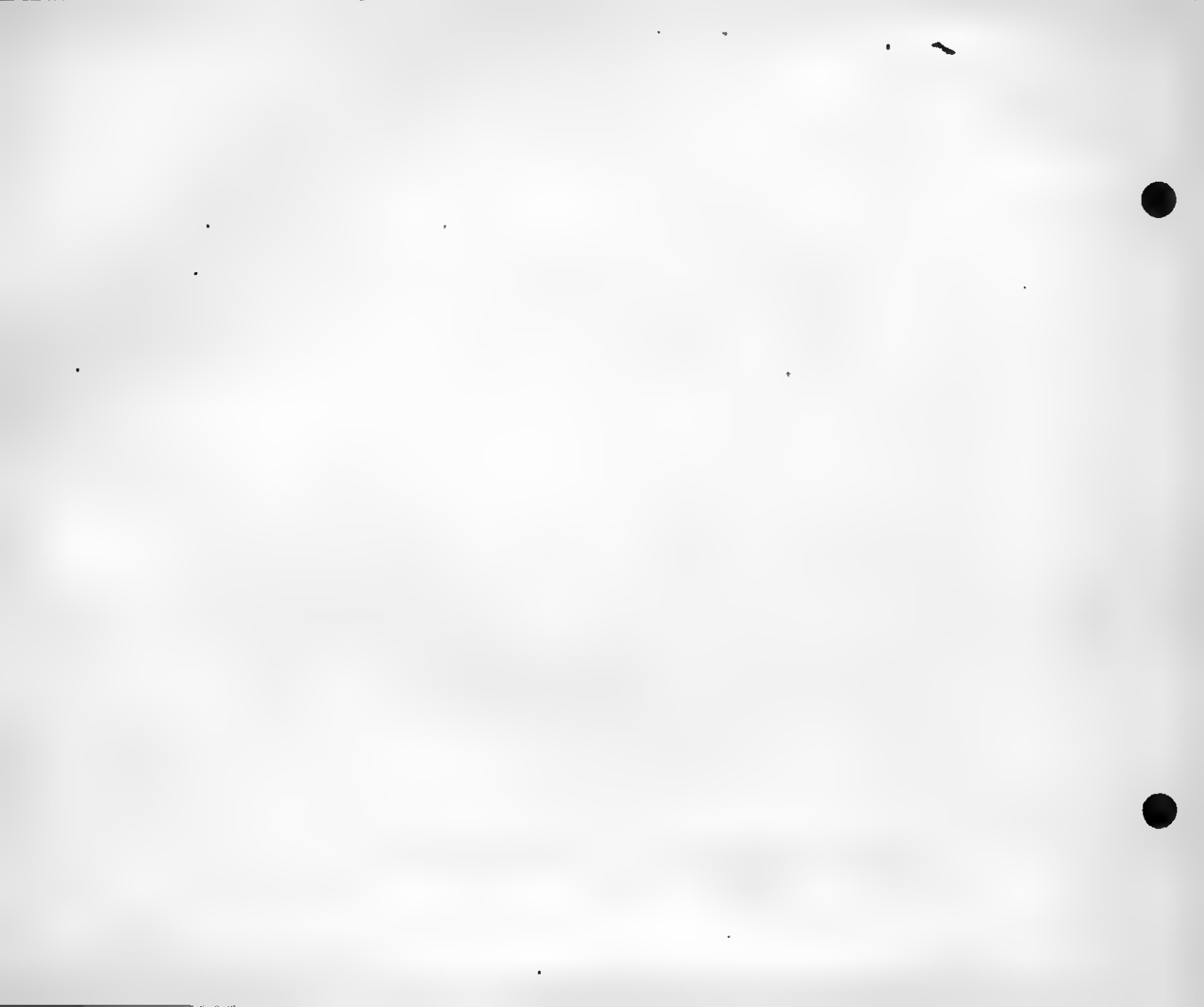
CERTIFICATE OF DEATH

10523

10521

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie (Baltimore)</u> c. LENGTH OF STAY IN <u>1 wk.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie (Baltimore)</u> d. STREET ADDRESS <u>Rt. 3 Box 99 Severn Md. 21144</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>William H. Tall</u> First Middle Last 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4 DATE OF DEATH <u>Aug. 10 1967</u> Month Day Year 8. DATE OF BIRTH <u>3/7/89</u> 9. AGE (In years last birthday) <u>78</u> yrs IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic - Ret.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Automotive</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Ezra Tall</u> 14. MOTHER'S MAIDEN NAME <u>Rose Roth</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Annie B. Tall, same as 2</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized peritonitis</u> DUE TO <u>ruptured duodenal ulcer</u> (b) <u>A-V dissection</u> DUE TO <u>Anterograde aortic dissection</u> (c) <u>dissection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 3, 1967</u> to <u>Aug. 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug. 10, 1967</u> , and that death occurred at <u>2:40 P.M.</u> from causes and on the date stated above.		22a. SIGNATURE <u>B. A. de Guzman</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>B. A. de GUZMAN, M.D.</u> 22d. ADDRESS <u>204 CRAIN HIGHWAY, GLEN BURNIE</u> 22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>12 Aug. 67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u> 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>		24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md. 21061</u> ADDRESS 25a. REC'D BY REGISTRAR <u>AUG 14 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



10524

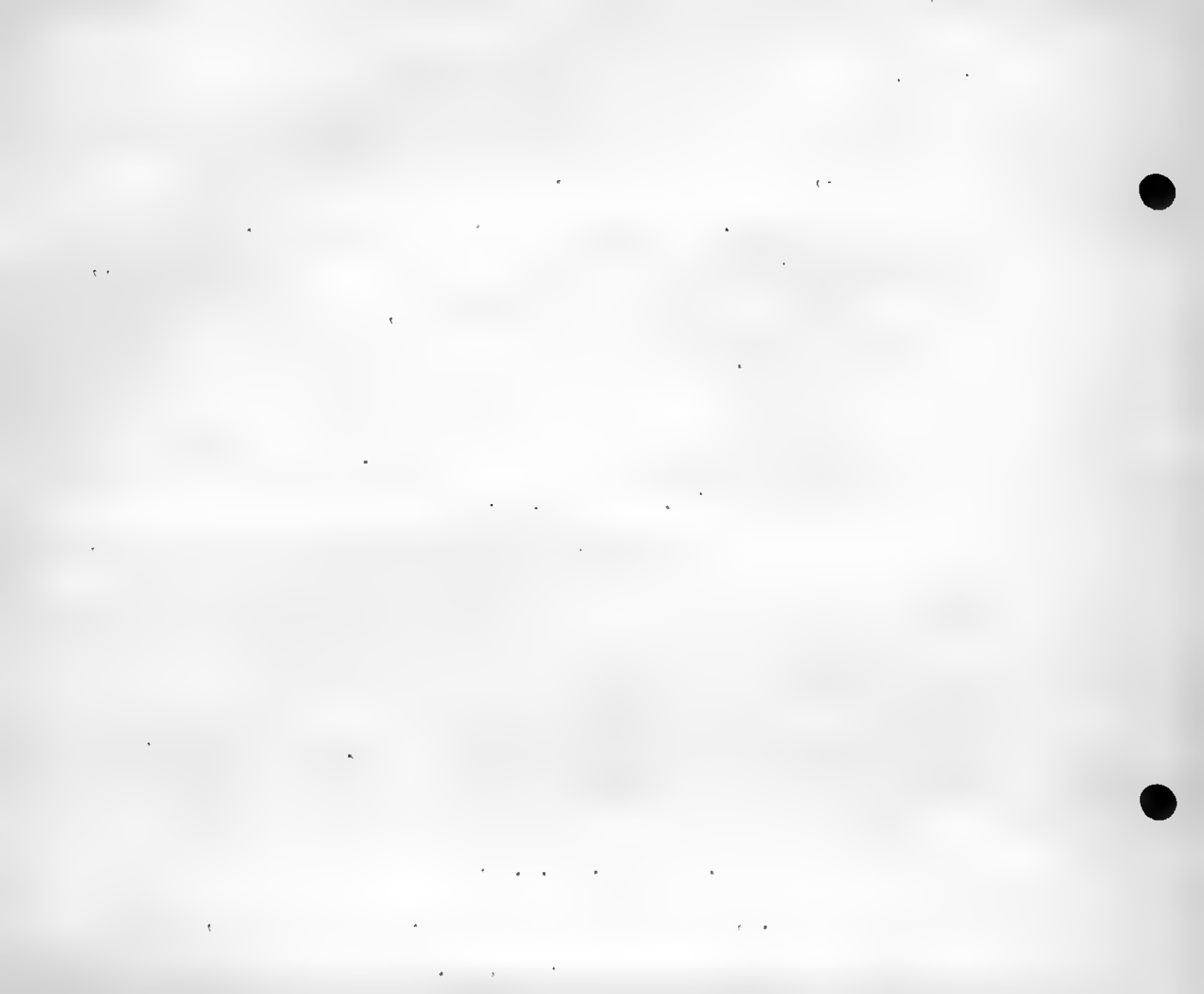
CERTIFICATE OF DEATH

10522

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>20 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>#113 Ferdinand Ave.</u>				d. STREET ADDRESS <u>#113 Ferdinand Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>ELEANOR</u> Last <u>TAYLOR</u>				4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 7, 1872</u>	9. AGE (n years last birthday) <u>95</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Peter Stallmann</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Address <u>#2</u> <u>Mrs Thelma E. Meseke (daughter) Same as</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4221 Cardio-Vascular Disease</u> DUE TO (b) <u>Arterio-Sclerosis</u> DUE TO (c) <u> </u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>10-15 1/2</u> <u>20 1/2</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/30</u> , 19 <u>67</u> , to <u>8/31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/31</u> , 19 <u>67</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Chas. L. Ball Jr.</u> M.D.				22b. DATE SIGNED <u>8/31/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Charles L. Ball Jr. M.D.</u>	
22d. ADDRESS <u>Linthicum Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>Sept. 4, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Singleton Funeral Home</u>				25a. REC'D BY REGISTRAR <u>Glen Burnie, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

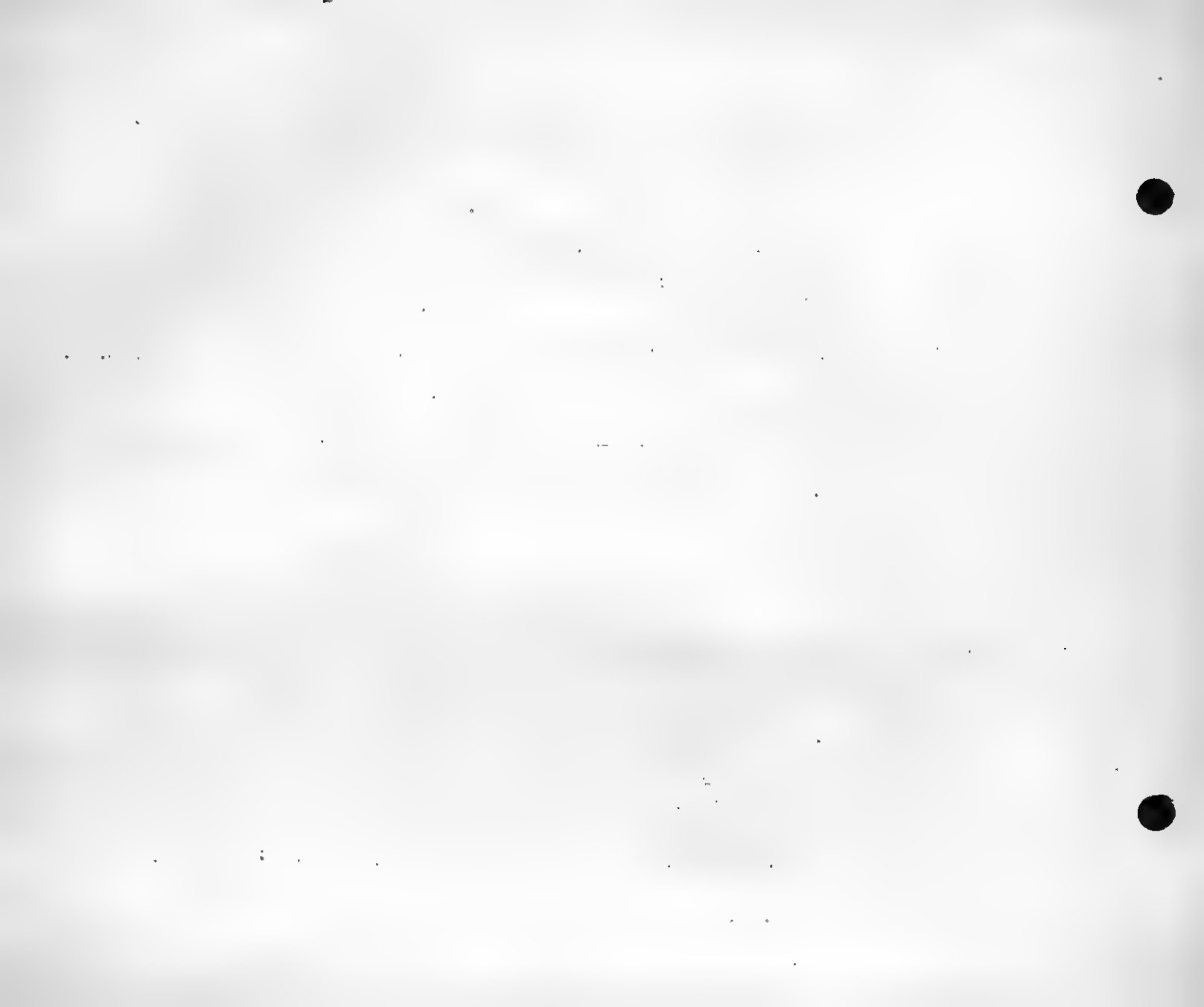
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10525					10523						
1. PLACE OF DEATH a. COUNTY XXX Anne Arundel MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Fort Smallwood Road					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena d. STREET ADDRESS R.F.D. 8 Box 308 Fort Smallwood Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Mildred Elizabeth Tribull			4. DATE OF DEATH Month August 29, 1967 Day 19 Year 19		5. SEX Female			6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Nov 16, 1908			9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing Machine Oper					10b. KIND OF BUSINESS OR INDUSTRY Tiffany Uniform		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Seitz					14. MOTHER'S MAIDEN NAME Barbare Hoener						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No (If yes give war or dates of service)					16. SOCIAL SECURITY NO. 217-03-3533		17. INFORMANT Mr. Gustave Tribull, Jr. Address Pasadena, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 7 1/2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from 10/14, 1957 to 8/29, 1967 , that (I) (we) last saw the deceased alive on Aug 27, 1967 , and that death occurred at 9:00 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Lester A. Wall Jr.					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/29/67				
22c. PHYSICIAN'S NAME (Type) LESTER A. WALL JR					22d. ADDRESS 1039 St Paul St Baltimore Md						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Sept. 1, 1967		23c. NAME OF CEMETERY OR CREMATORY Oaklawn		23d. LOCATION (City, town or county) (State) Baltimore Co., Md.				
24. FUNERAL DIRECTOR McCully Funeral Home ADDRESS 237 Patapsco Ave. 21225					25a. REC'D BY REGISTRAR AUG 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and no event, within 72 hours after death.

VR A15 (4)
20 M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10526

CERTIFICATE OF DEATH

10524

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN lb North Arundel Hospital d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie d. STREET ADDRESS 908 Roseanne Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gora Stroupe Underwood 4. DATE OF DEATH August 14 1967		5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 10-30-79 9. AGE (In years last birthday) 87 yrs IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker 10b. KIND OF BUSINESS OR INDUSTRY North Carolina 11. BIRTHPLACE (County & State, or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY?		3. FATHER'S NAME John Hoover 14. MOTHER'S MAIDEN NAME Lenora 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Alma Underwood, 908 Roseanne, Road Address Glen Burnie, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myo cardiac infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Melvin Ventura 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED 8-14-67 M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-16-1967	
23c. NAME OF CEMETERY OR CREMATORY Snow Hill Meth. Ch. Cem.		23d. LOCATION (City or Town) (County) (State) Gaston County, Luica, N. C.	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR DATE AUG 16 1967 25b. REGISTRAR'S SIGNATURE J. J. Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 10525

1. PLACE OF DEATH a. COUNTY Anne Arundel County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 8467 Garden Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AGNES Middle BERTHA Last VOLLMER		4. DATE OF DEATH Month AUGUST Day 20 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27, 1921
9. AGE (In years last birthday) 46		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Hoffberger Fuel Oil Baltimore, Md.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel J. Smith		14. MOTHER'S MAIDEN NAME Lena Beswick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 213-18-6862	
17. INFORMANT Mr. Robert W. Vollmer		Address 8467 Garden Road 21122	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PEPTIC ULCER</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>JUNE, 1965</u> to <u>AUGUST, 1967</u> , that I last saw the deceased alive on <u>8/1, 1967</u> , and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Brady Smith</u>		DATE SIGNED <u>8/26/67</u>	
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>		ADDRESS (Street, city or town, state) <u>8471 FT. SMALLWOOD ROAD PASADENA, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/23/67	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) A. A. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Home</u>		ADDRESS <u>237 Potomac Ave</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 23 1967</u>		24b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10526

10526

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on- Residence before admiss on) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospita, give street address) NAVAL HOSPITAL				d. STREET ADDRESS 7618 INWOOD STREET			
3. NAME OF DECEASED (Type or print) First Middle Last SUSAN E. WALKER				4. DATE OF DEATH Month Day Year AUGUST 28 19 67			
5. SEX FEMALE	6. COLOR OR RACE CAUC.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 OCT 1949		9. AGE (In years last birthday) 17 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY SCHOOL		11. BIRTHPLACE (County & State, or foreign country) Honolulu Hawaii		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JACK H. WALKER				14. MOTHER'S MAIDEN NAME MARIE E. SHULL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO -		17. INFORMANT JACK H. WALKER		Address # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 0570 CARDIO-RESPIRATORY ARREST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Acute Hydrocephalus DUE TO (b) Acute Meningococcal Meningitis DUE TO (c) 9 days							INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 20 Aug , 19 67 , to 28 Aug , 19 67 that (I) (we) last saw the deceased alive on 28 Aug , 19 67 , and that death occurred at 10:00 PM , from causes and on the date stated above.							
22a. SIGNATURE Michael F. Fornes M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 8/28/67	
22c. PHYSICIAN'S NAME (Type) M. F. FORNES, LCDR MC USN				22d. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD.			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		8-30-67		Herrington NATL.		Herrington Va.	
24. FUNERAL DIRECTOR JOHN M. TAYLOR & SONS, DUKE OF GLOUCESTER ST. ANNAPOLIS, MD.				25a. REC'D BY REGISTRAR AUG 30 1967		25b. REGISTRAR'S SIGNATURE James Judge	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10527

10526

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>AA CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if inst. tut. on Res. dence before admitt. on) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Anna Pott's</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bucktown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>S. O. N. - Anna Pott's</u>		d. STREET ADDRESS <u>5445 Fair Lawn Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Benjamin Weingarten</u>		4. DATE OF DEATH Month <u>8</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-16-09</u>
9. AGE (In years last birthday) <u>58</u> yrs		10. IF UNDER 1 YEAR Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electrical</u>	
11. BIRTHPLACE (State or foreign country) <u>Phila., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Morris Weingarten</u>		14. MOTHER'S MAIDEN NAME <u>Bessie ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. Mary Weingarten</u>		Address <u>5445 Fair Lawn Avenue</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work or Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>5-15-67</u>	
ACTUAL SIGNATURE <u>F. Levinson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, & county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/21/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Shaaron</u>		23d. LOCATION (City or town) (County) (State) <u>Springfield, Pennsylvania</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u>		25a. REC'D BY REGISTRAR <u>AUG 25 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10530

10528

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if not in residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 12 Bricin St., Apt-101,	
3. NAME OF DECEASED (Type or print) Bennett Clayton WHEELER		4. DATE OF DEATH Month August Day 8 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30, 1911
9. AGE (In years last birthday) 55 yrs		10. IF UNDER 1 YEAR Months 5 Days 19 Hours 67 Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Central Office Repman		11b. KIND OF BUSINESS OR INDUSTRY public utilities	
11. BIRTHPLACE (County & State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert C. Wheeler		14. MOTHER'S MAIDEN NAME Gertrude Nichols	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-05-1010	
17. INFORMANT Mary M. Wheeler - Annapolis, Md.		1804 Bary Ridge Ave.,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dysentery DUE TO Aldonoid (b) acute DUE TO anurism (c) anurism		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) Stephen B. Hiltabidle attended the deceased from Aug. 8, 1967 , to Aug. 8, 1967 , that (I) (we) saw the deceased alive on Aug. 8, 1967 , and that death occurred at 5:20 PM M, from causes on and on the date stated above.			
22a. SIGNATURE Stephen B. Hiltabidle M.D.		22b. DATE SIGNED 8/10/67	
22c. PHYSICIAN'S NAME (Type) Stephen B. Hiltabidle, M.D.		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial (Crypt)	23b. DATE THEREOF 8/11/67	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery	23d. LOCATION (City or Town) (County) (State) Annapolis, Md.
24. FUNERAL DIRECTOR Beverly E. Hopping		25a. REC'D BY REGISTRAR Charles Judge	
Hopping Funeral Home - Annapolis, Md.		DATE AUG 14 1967	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

10531

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10529

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 2448 Spellman Road	
3. NAME OF DECEASED (Type or print) Marion		4. DATE OF DEATH Month Day Year August 13, 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/9/10
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marion White		14. MOTHER'S MAIDEN NAME Epsie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Ida White 3448 Spellman Rd.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 9299 Drowning IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from bridge into water	
20c. TIME OF INJURY Month, Day, Year a.m. 8/11 1967 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Water	20f. (City or town) (County) (State) Anne Arundel, Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 8/14/67	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/19/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Charles A. Rice 661 W. Barre St.		25a. REC'D BY REGISTRAR DATE AUG 16 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

THE HOUSE OF REPRESENTATIVES

1890

REPORT OF THE

COMMISSIONER

OF THE

1890

DEPARTMENT OF THE INTERIOR

UNITED STATES

WASHINGTON, D. C.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10532

10530

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY A.A.Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE WASH-DC b. COUNTY 47-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A - ANNE-ARMONEL-HOSPITAL		d. STREET ADDRESS 2705-13th St. - N.E.	
3. NAME OF DECEASED (Type or print) JAMES Edgar Williams		4. DATE OF DEATH Month 8 Day 9 Year 1967	
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/30/07
9. AGE (In years lost birthday) 60 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S.P. O.	
11. BIRTHPLACE (State or foreign country) DANVILLE, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PEMBERTON WILLIAMS		14. MOTHER'S MAIDEN NAME ADDIE LUCK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT BERNICE D. WILLIAM		Address 425 KANSAS AV. WASHINGTON, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 851X IMMEDIATE CAUSE (a) Choking DUE TO (b) Stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Bathtub accident	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 5/9 p.m. 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> Choking	
20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.)		20f. (City or town) (County) (State) ARAC 40	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. L. Linhart		22. DATE SIGNED 8-9-67	
EXAMINER'S NAME (Type) E. L. Linhart		M.D. Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/13/67	
23c. NAME OF CEMETERY OR CREMATORY OAK HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) DANVILLE, VIRGINIA	
24. FUNERAL DIRECTOR McGuire Funeral Service Inc.		25a. REC'D BY REGISTRAR WASHINGTON, D.C.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE AUG 14 1967	

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AGRICULTURE

RESEARCH DIVISION

DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

UNITED STATES DEPARTMENT OF AGRICULTURE

RESEARCH DIVISION